FINANCIAL REPORT

Fiscal Year 1994

Health Care Financing Administration
U.S. Department of Health and Human Services

Fiscal Year 1994
HCFA Financial Report

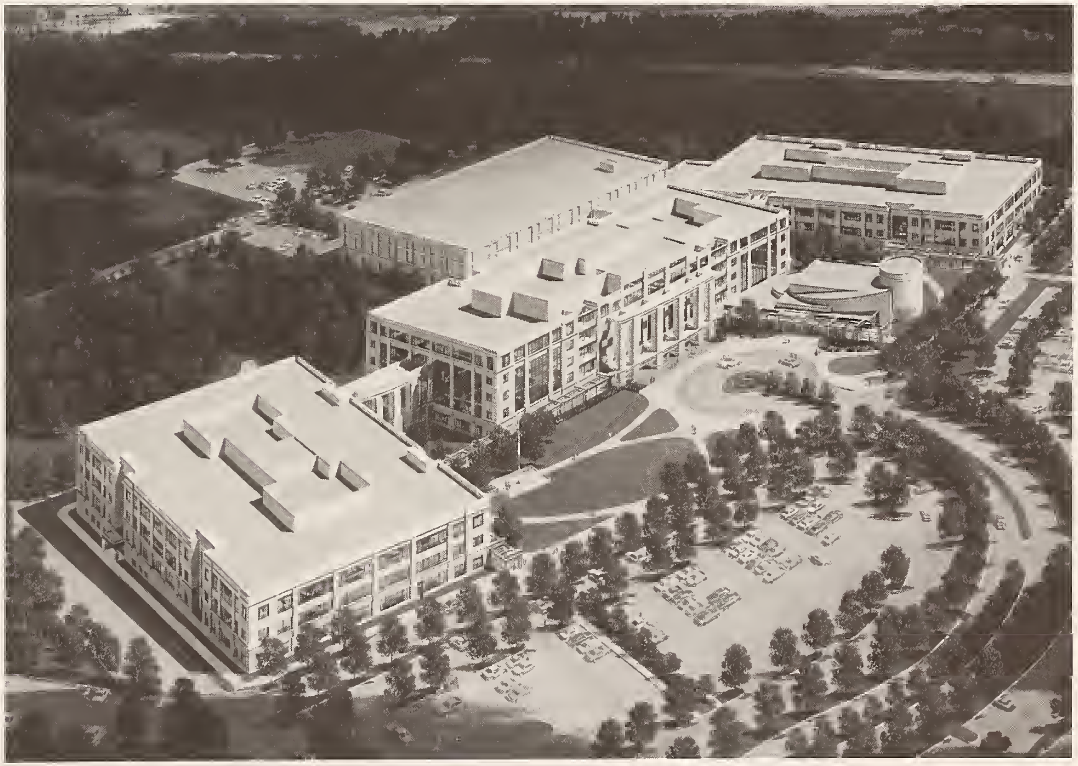
The Chief Financial Officers Act of 1990 (P.L. 101-576) marks a major effort to improve U.S. Government financial management and accountability. In pursuit of this goal, it instituted a new Federal financial management structure and process modelled on private sector practices. The CFO Act established in all major agencies the position of Chief Financial Officer with responsibilities including annual publication of financial statements and an accompanying report.

This Financial Report is HCFA's third CFO Act submission. Its form and content follow guidance provided by the Department of Health and Human Services, the Office of Management and Budget, and the Federal Accounting Standards Advisory Board. It reflects HCFA's strong support of the spirit and requirements of the CFO Act and our continuing commitment to improve agency financial reporting.

U.S. Department of Health and Human Services
Health Care Financing Administration
7500 Security Boulevard
Baltimore, Maryland 21244

HCFA Financial Report

Fiscal Year 1994



New National Headquarters of the Health Care Financing Administration

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HCFA Financial Report

Fiscal Year 1994

Message from the Administrator

In Fiscal Year 1994, the Health Care Financing Administration (HCFA) continued to carry out its basic mission of ensuring access to high quality health care for over 70 million Americans in the Medicare and Medicaid programs while at the same time streamlining and downsizing the agency, implementing the National Performance Review, fleshing out its strategic plan, and participating in the consideration of health care reform. FY 1994 was an unusually busy, intense, and productive year even for an agency which is normally busy, intense, and productive.

These financial reports reflect the remarkable achievements of this agency. Day in and day out, handling millions of health care claims, providing information to beneficiaries, monitoring the quality of care, improving policies and procedures, the talented and hard-working individuals of HCFA and HCFA's contractors carry out one of the most important and difficult tasks in government. We provided $171 billion in health benefits to 37 million Medicare beneficiaries at an operating cost of only 1.5% of total expenses.

Prudent financial management is increasingly critical in this era of severely limited Federal resources. As an agency with one of the largest and fastest growing budgets in the Federal government, we in HCFA have a special obligation to ensure that we spend each dollar, whether for benefits or administration, as wisely as possible. The process of developing the annual financial report audited by the Office of Inspector General (OIG) of the Department of Health and Human Services helps us improve our financial management by highlighting areas requiring increased attention. For example, we are making improvements in contractor control of Medicare accounts receivable and payable. In all areas of financial management, we are working in partnership with the Inspector General to make continuous improvements in keeping with the principles of Total Quality Environment.

Our focus continues to be on providing the best possible service to our primary customers, the beneficiaries of the programs. A key element of excellence in customer service is ensuring the financial integrity and efficiency of HCFA programs and administration. I believe that these financial reports reflect our strong commitment to continuing improvement in financial management.

Bruce C. Vladeck
Administrator

June 1995

Message from the Chief Financial Officer

As HCFA's Chief Financial Officer, I am pleased to report that in Fiscal Year 1994 we continued to make significant progress in improving financial management in HCFA in many key areas, such as strategic planning, the Federal Managers' Financial Integrity Act (FMFIA), and Medicare and Medicaid accounting activities.

In FY 1994, we began to implement our new strategic plan in many ways. One of the most important was developing our proposed FY 1996 budget around the themes and goals of the strategic plan. During the year, our FY 1994 budget allocation decisions were made by an intra-agency workgroup within the context of making strategic decisions on how to most effectively use resources to move forward the goals and objectives of the strategic plan. We continued to refine the objectives, tasks, and critical success factors under strategic plan goal 5, "Promote fiscal integrity of HCFA programs." We have particularly stressed improving financial oversight and taking aggressive action to eliminate fraud and abuse.

Under FMFIA, we have streamlined operations and focused upon supporting the goals and objectives included in HCFA's strategic plan. Working independently and in concert with the Department of Health and Human Services (DHHS) we are pursuing a proactive approach to FMFIA throughout the Agency by removing nonregulatory internal controls, unnecessary reporting, and burdensome instructions. In addition, we have initiated a pilot project to assist Medicare contractors in assessing the effectiveness of their key internal controls. A protocol has been developed for this purpose and is being tested at Blue Cross of Georgia. The protocol assesses internal controls over the total range of contractor functions including financial management and automated data processing. We plan to review the results of the pilot and to consider, through the use of a contractor, Office of Inspector General (OIG) and a HCFA workgroup, the applicability of a self-assessing protocol for all Medicare contractors.

HCFA has also made significant progress in re-engineering efforts in the accounting area. HCFA became the first Operating Division in the DHHS to implement direct deposit of employee travel reimbursement and is currently working on an automated travel system that will reimburse travel expenses in our ten regions. The Division of Accounting (DA) implemented a policy whereby a credit card is used to obtain employee travel advances, reducing the record-keeping process within DA. In addition, we moved forward with eliminating the more costly, paper-intensive procurement process for small dollar items and replacing it with the use of credit cards. Automating the receipt of Medicare contractor payment data into HCFA's core accounting system and instituting host-to-host electronic

Message from the Chief Financial Officer (continued)

transfer of HCFA's vendor payments have contributed to DA's ability to meet its responsibilities even as full-time equivalent (FTE) levels are being reduced. The efforts mentioned have saved thousands of dollars in administrative costs for HCFA.

HCFA continues to improve Medicare accounting by reviewing Medicare contractor CFO reports which were developed in FY 1993 to account for accrual data and by communicating back to the contractors those areas that may need improvement based on the analysis of national data. The Medicare contractors have also been provided with contacts in the operations and accounting areas within HCFA to assist them in the preparation of the CFO reports. The above mentioned internal control protocol will address this area. Training sessions for the Medicare contractors have been planned to continue the effort to improve and standardize financial data reported by the contractors. In addition, the OIG served, at HCFA's request, on a Medicare Transaction System (MTS) workgroup to ensure its concerns are met in the design of a fully integrated accounting system within the MTS.

Having the most efficient and effective financial system is a key goal of this agency. In striving to meet this goal, HCFA addressed several of the concerns that the OIG has focused on in past financial reports. In the area of Medicare accounts payable, HCFA revised its National Claims Processing Report to provide data on claims incurred in a prior fiscal year but paid in the current fiscal year in order to substantiate the accounts payable balance on HCFA's FY 1993 financial statement. HCFA responded to the Medicare accounts receivable issue by implementing a separate report of Medicare Secondary Payer (MSP) accounts receivable as a corrective action for the MSP high risk area that HCFA has declared. This report is part of the ongoing activity to improve financial reporting and internal controls by the Medicare contractors. HCFA has also addressed the OIG's concerns regarding Medicaid accounts receivable by requesting that the Federal Accounting Standards Advisory Board provide standard guidance as to whether Federal agencies that fund State grants must include the States' accounts receivable and payable on Federal financial statements.

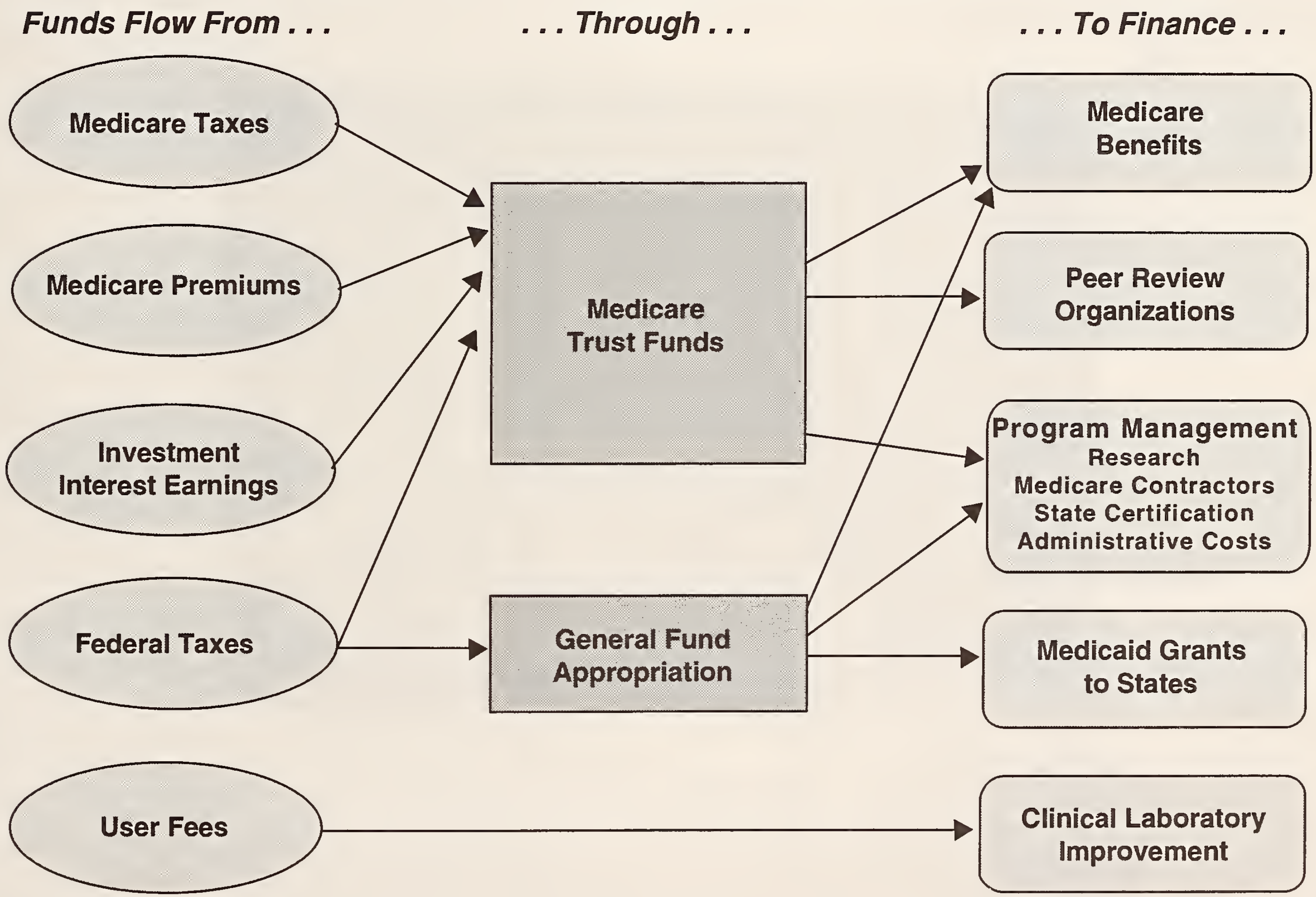
HCFA takes its financial management responsibilities very seriously. We will continue to improve our financial systems, accounting procedures, and reporting processes to reflect our goal to have the best financial management system in Government.

William F. Broglie

William F. Broglie
Chief Financial Officer

June 1995

Financing of HCFA Programs & Operations



Chapter 1

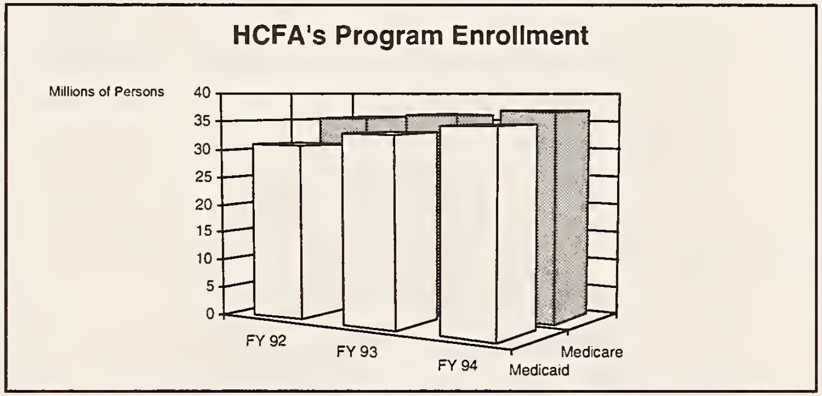
Executive Summary

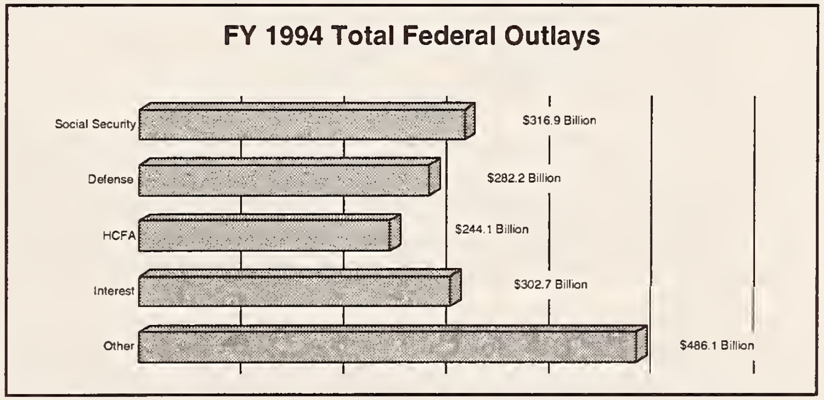
Medicare had 37 million beneficiaries and HCFA incurred $171 billion in expenses ($162.1 billion in outlays) for health care services for America's aged and disabled in FY 1994. Medicaid had 34.9 million beneficiaries and HCFA incurred $87 billion in expenses ($82 billion in outlays) for the Federal share of health care services in FY 1994. Medicare and Medicaid are administered through private contractors and State and local government agencies, respectively. HCFA provides funding, policy guidance, and quality review for the programs.

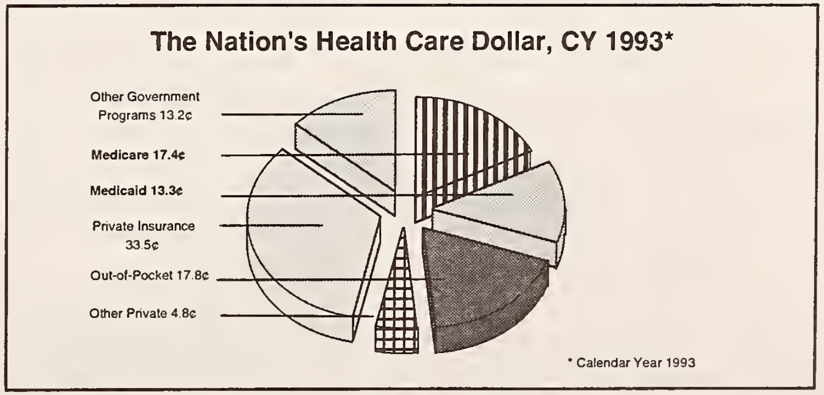
In FY 1994, HCFA incurred total expenses of $259.7 billion and outlayed $244.1 billion. The latter equaled 15% of the total Federal budget,which is the third largest share of Federal spending after Social Security and Defense. HCFA spending for Medicare and Medicaid increased 10.3 percent from FY 1993 to FY 1994, over four times faster than the general cost of living as measured by the Consumer Price Index (CPI), and twice as fast as the CPI for medical goods and services. Medicare spending grew 11.4 percent and Medicaid spending rose 8.3 percent.

For calendar year 1993, Medicare and Medicaid outlays represented 30.7 cents of every dollar spent on health care in the United States—45.3 cents of every dollar received by U.S. hospitals, and 27.6 cents of every dollar received by other health care providers. (Data for calendar year 1994 is not yet available.)

In addition to establishing rules for eligibility and benefit payments, paying Medicare benefits and providing States with matching funds for Medicaid benefits, HCFA carries out many other important activities:







- HCFA is responsible for assuring the safety and quality of medical facilities, providers, and suppliers through setting standards, conducting inspections, and certifying providers as eligible for program payments, and ensuring that corrective actions are taken where deficiencies are found. HCFA also monitors the quality of care provided to Medicare beneficiaries through the Peer Review Organization (PRO) program.
- HCFA conducts an extensive program of research, demonstrations, and grants aimed at helping improve the quality of health care, access to care, the efficiency of delivery and payment systems, and other important improvements in the health care system.
- HCFA maintains the Nation's largest collection of health care data and provides data and analytical services to the Congress, other parts of the Executive Branch, non-government analysts and researchers, as well as internal users.
- HCFA promotes managed care and assures that Federally qualified HMO's meet quality, benefit, and financial integrity standards.
- HCFA, through the Clinical Laboratory Improvement Act (CLIA) program, helps assure the quality and reliability of laboratory testing for all Americans.
- HCFA oversees State regulation of private Medigap insurance to ensure that Medicare beneficiaries are afforded important consumer protections.

To accomplish its mission, HCFA is staffed by about 4,100 Federal employees, but carries out most operational activities through contractors, as follows: (1) 26,000 employees at 81 claims processing contractors, which include four Durable Medical Equipment Regional Carriers; (2) 5,500 employees at 53 State survey agencies, which include surveyors, clerical and support staff; (3) 2,220 employees at 53 Peer Review Organizations; and (4) approximately 40,000 employees in State Medicaid agencies. The Social Security Administration and other Federal agencies also provide thousands of other staff either full or part-time for Medicare or Medicaid operations.

There are 2,600 employees located at HCFA headquarters in Baltimore and Washington. The staff is engaged in policy development, direction, and coordination; operational guidance and monitoring; survey and certification management; legislative planning; research; data and systems management; public information and liaison; and administrative services. In addition, there are 1,500 employees located in 10 regional offices around the country who oversee HCFA operations in their areas and deal directly with Medicare contractors, State agencies, providers, program beneficiaries, and the general public.

Program Management encompasses the funding, through the annual Labor/HHS/Education Appropriations Act, of the operational and administrative expenses of Medicare, the Federal portion of Medicaid, and other agency responsibilities. There are four principal budget activities within Program Management—

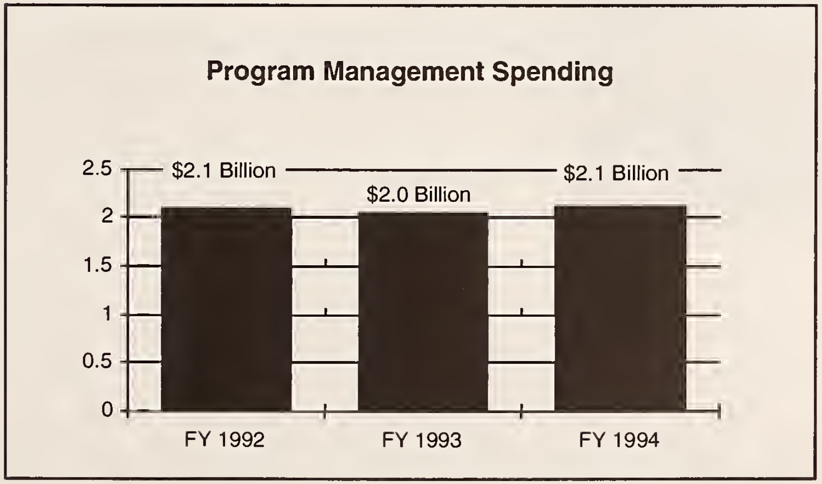
- Medicare Contractors
- Administrative Costs
- State Certification
- Research

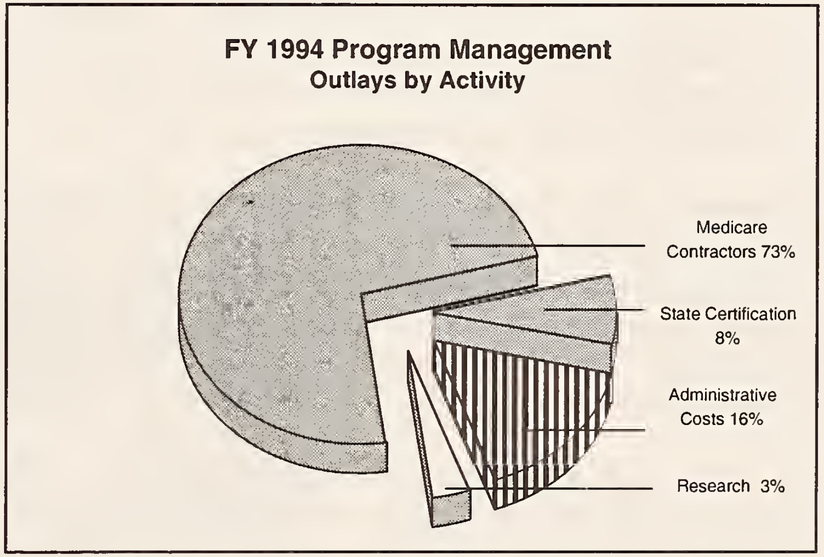
Since FY 1984, Program Management obligations have increased at an average annual rate of 6 percent, while benefit outlays have grown 9 percent per year.

Some of the same forces driving up program benefit obligations also affect HCFA's operational costs, such as the aging of the population (resulting not only in an increase in program enrollment but also in the use of medical services). HCFA has so far succeeded in increasing operational efficiency and productivity to keep the rate of Program Management cost increases to a reasonable level. This becomes more difficult each year, as the numbers of beneficiaries and associated workloads continue to grow and HCFA's work becomes more complex.

Program Management spending grew slightly from $2.0 billion in FY 1993 to about $2.1 billion in FY 1994.

Medicare Contractors account for nearly three quarters of Program Management outlays.





Recognizing the severe restraints appropriated discretionary funding will continue to face even as mandatory entitlements such as Medicare and Medicaid expand rapidly, we are committed to a comprehensive program of productivity, service, and quality improvement. In FY 1994, we continued to develop the HCFA strategic plan, aggressively implemented programs to empower HCFA employees to develop process improvements, continued planning the Medicare Transaction System, and completed the transition of paying for durable medical equipment to specialized contractors. HCFA faces increasingly difficult challenges in the years ahead and we are moving aggressively to prepare ourselves for the future.

To ensure continuous focus on improving the quality and efficiency of all aspects of HCFA's work and to prepare for future changes in the Nation's health care delivery and

financing systems, HCFA is currently engaged in a comprehensive strategic planning activity. This activity defines HCFA's vision for the future, its basic mission, and strategic goals. We are revising the strategic plan to respond to comments received.

HCFA's final strategic plan will include specific performance indicators, or critical success factors, by which progress toward achieving strategic goals can be measured. In future financial statements, we plan to key the information presented to the strategic plan. The HCFA strategic plan is discussed further in the next section of this overview.

The HCFA strategic plan will be the organizing focus for all HCFA activities, both our ongoing responsibilities and our preparations for the future. HCFA faces many important issues, and if past experience is any guide, unanticipated issues will develop which will require us to adjust and refine our plans and priorities. Some of the major issues HCFA faces include:

- Continuing program cost increases straining Trust Fund solvency and general fund deficits requiring further budget reductions;
- Implementing National Performance Review recommendations to streamline internal processes and to eliminate barriers to efficiency;
- Developing and implementing a national health care database which will lead the nation in health care information resources management;
- Designing and developing a Medicare Transaction System which will standardize and improve the efficiency of Medicare claims processing;
- Enhancing beneficiary choice by expanding the participation of managed care programs in Medicare as a cost-effective alternative to fee-for-service;
- Assisting States to develop and implement Medicaid reform initiatives;
- Improving beneficiary access to quality health care in all sectors of State Medicaid programs;
- Promoting beneficiary awareness and understanding by enhancing educational, informational, and outreach activities with beneficiary, professional, provider, and business organizations; and
- Reducing program costs through increased fiscal reviews, third party oversight, and secondary payer activities.

Chapter 2

HCFA Strategic Plan

HCFA's strategic plan sets forth the agency's mission and vision and the goals, objectives, and strategies we will pursue to reach our vision. Through strategic planning, HCFA is preparing carefully and purposefully for the future. The plan's goals, objectives, and strategies are not static but will be updated as our environment and priorities change. HCFA is committed to incorporating strategic thinking in performing our everyday work throughout the agency. This plan represents HCFA's pledge to improve the quality of the Agency's activities in order to best serve our customers.

HCFA's strategic plan is unified by several underlying, recurring themes:

Investing in our employees

Improved service to beneficiaries

Building partnerships and teamwork

Improved communications

More efficient utilization of resources

If we are to be successful, we must empower our staff and use customer-defined needs as the primary means of improving our processes, evaluating our ability to serve, and establishing the partnerships and team arrangements needed for the sake of our customers.

The HCFA strategic plan was used in developing HCFA's FY 1996 budget request and will be used in HCFA's work planning. Senior managers in HCFA recognize the importance of updating the plan periodically to reflect changes in program and operational activities as well as reporting accomplishments achieved under the strategic plan. The strategic plan demonstrates HCFA's total commitment to become a proactive agency.

OUR MISSION

WE ASSURE HEALTH CARE SECURITY FOR BENEFICIARIES

Health care security means:

- Access to affordable and quality health care services;
- Protection of the rights and dignity of beneficiaries; and
- Provision of clear and useful information to beneficiaries and providers to assist them in making health care decisions.

In serving the health care security needs of beneficiaries, we work together as a team and in partnership with others and value the contributions each of us makes.

OUR VISION

WE GUARANTEE EQUAL ACCESS TO THE BEST HEALTH CARE

The vision reflects our commitment that:

- All individuals will be given an unconditional assurance of having the same opportunity to have their health care needs met, regardless of location, income, or other circumstances; and

- The quality of health care they receive is the best that can be provided.

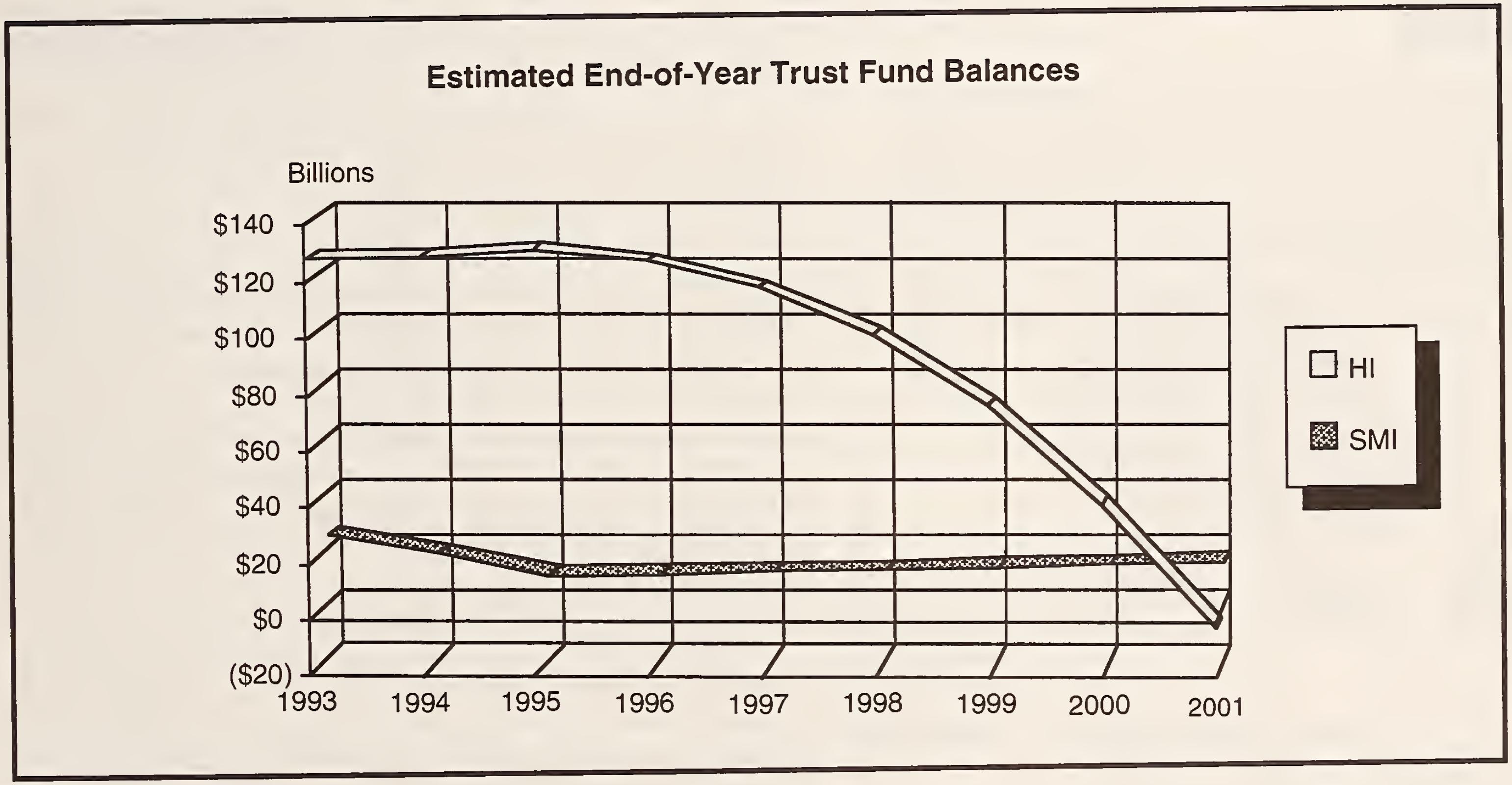
GOALS

Goals help us realize our vision and serve as a guide for our work over the next several years. All of the goals are interrelated. Each goal is supported by a set of objectives, which in turn is supported by a set of strategies. Critical success factors are currently being developed to measure our progress toward meeting our goals, which are:

1. Build a high-quality, customer-focused team.
2. Ensure programs and services respond to the health care needs of beneficiaries.
3. Promote improved health status of beneficiaries.
4. Be a leader in health care information resources management.
5. Promote fiscal integrity of HCFA programs.
6. Create excellence in the design and administration of our programs.
7. Provide leadership in the continuing evolution of the health care system.

Chapter 3

Medicare

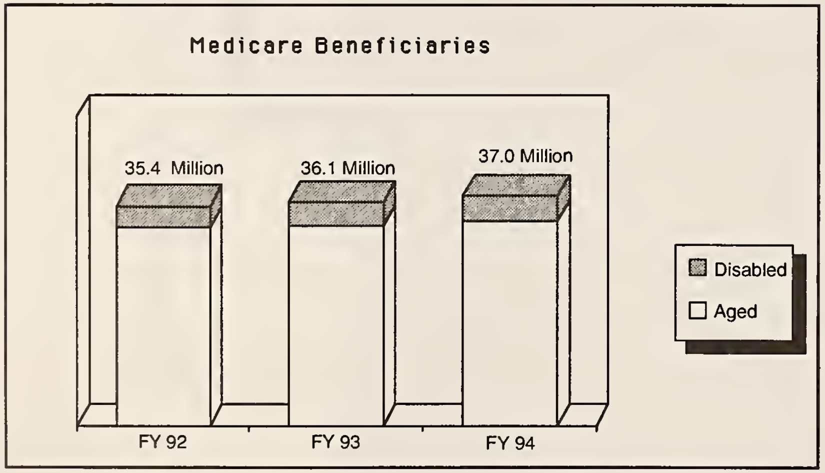


Key Fact

The 1994 Trustees Report of the Hospital Insurance Trust Fund projected depletion of the fund in 2001.

Program Profile

Title XVIII of the Social Security Act was established by the Social Security Amendments of 1965. Legislated as a complement to Social Security retirement, survivors, and disability benefits, Medicare originally covered people aged 65 and over. Since 1966, when Medicare was implemented, the program has been broadened to cover the disabled, people with end-stage renal disease, and certain others who elect to purchase Medicare coverage.



Medicare is a combination of two programs, each with its own enrollment, coverage, and financing—Hospital Insurance and Supplementary Medical Insurance.

Hospital Insurance

Hospital Insurance, also known as HI or Medicare Part A, is generally provided automatically to people aged 65 and over who have worked long enough to qualify for Social Security benefits and to most disabled people entitled to Social Security or Railroad Retirement benefits. HI pays participating hospitals, skilled nursing facilities, home health agencies, and hospice providers for covered services rendered to Part A enrollees.

Part A is financed through the HI Trust Fund, whose revenues come primarily through Medicare's portion of payroll and self-employment taxes collected under the Federal Insurance Contribution Act (FICA) and Self-Employment Contribution Act (SECA). In 1994, the Medicare payroll tax rate was 2.9 percent of annual wages — all employees and employers were required to contribute 1.45 percent of employees' wages, with no limitation, to the HI Trust Fund. The self-employed paid the full 2.9 percent.

Supplementary Medical Insurance

Supplementary Medical Insurance, also known as SMI or Medicare Part B, is available to nearly all people aged 65 and over, and to disabled people entitled to Part A. SMI covers physician and outpatient care, laboratory tests, durable medical equipment, some therapy services, and some other services not covered by HI.

SMI coverage is optional and subject to monthly premium payments by beneficiaries. About 95 percent of HI enrollees elect to enroll in SMI.

The 1994 SMI premium, set by statute, was $41.10 per month. Beneficiary premiums accounted for 28.1% percent of SMI revenues. The remainder was provided by appropriated Federal general revenues.

FY 1994 Highlights

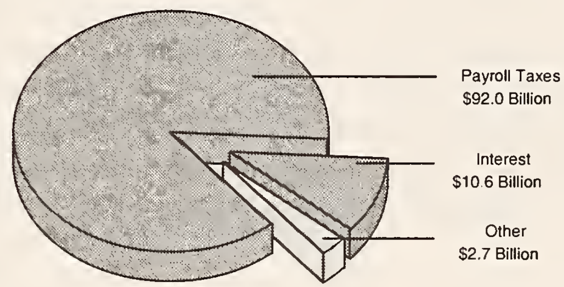
Status of the Trust Funds

The 1994 Report of the HI Board of Trustees projected, under intermediate actuarial assumptions, that the HI Trust Fund will be depleted in 2001. The Trustees (the Secretaries of the Treasury, Health and Human Services, Labor, and two public trustees) recommended that legislative action be taken to bring the HI program into actuarial balance.

Unlike HI, which is financed primarily by payroll tax revenues based on statutory provisions covering several years, most current SMI costs are financed on a current-year basis through appropriations of Federal general revenues and beneficiary premiums. The SMI Board of Trustees reported that the SMI program is actuarially sound, but noted that the rapid rate of program outlay growth requires legislative action to control SMI costs.

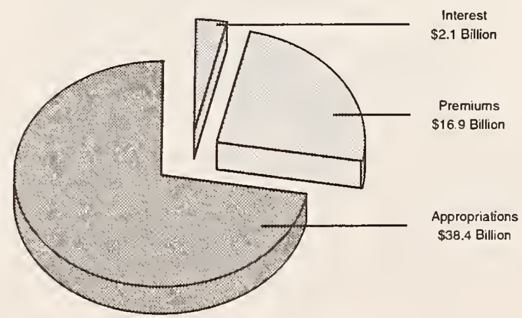
The 1995 Reports of the Boards of Trustees of the HI and SMI Trust Funds will be issued soon and will show revised projections based on more recent data.

FY 1994 HI Income



Total Income = $105.3 Billion

FY 1994 SMI Income



Total Income = $57.4 Billion

Trust Fund Income

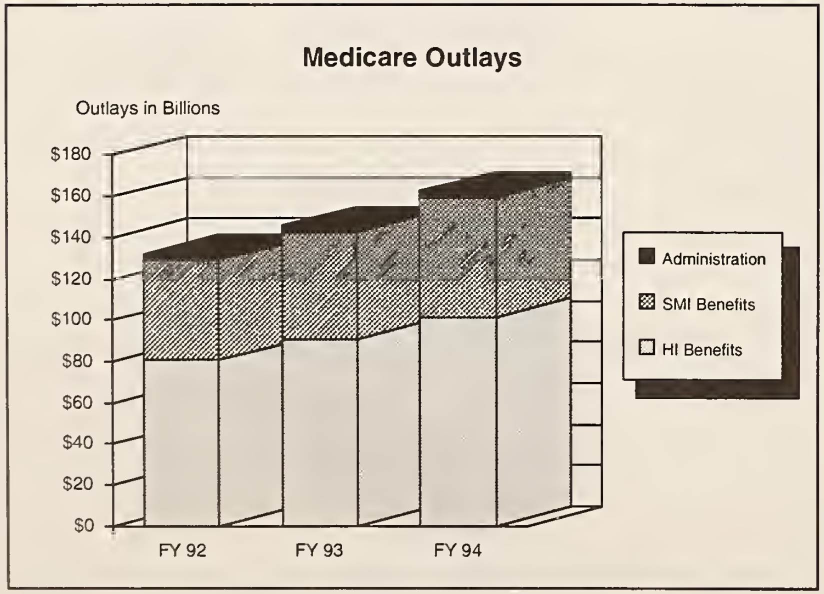
Medicare Trust Fund income totalled $162.7 billion in FY 1994, a 4.6 percent increase over FY 1993, compared with the 11.4 percent increase in Medicare outlays.

HI Trust Fund income was $105.3 billion, 8.7 percent more than in FY 1993. SMI income decreased almost 2.4 percent to $57.4 billion.

Trust Fund Outlays

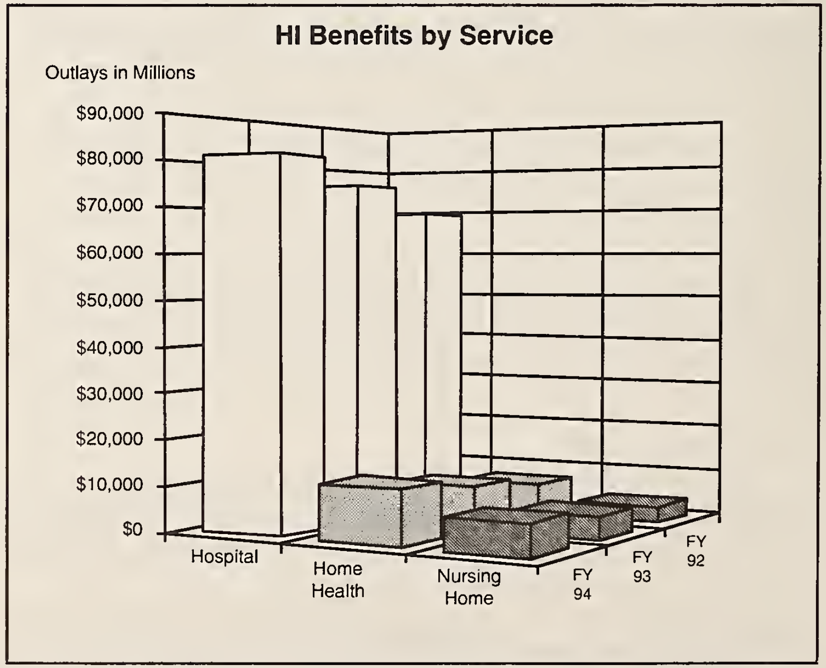
Total Medicare outlays, including benefit payments, Peer Review Organization spending, and administrative costs, increased 11.4 percent over FY 1993. HI Trust Fund outlays were $102.4 billion in FY 1994, 12.2 percent more than in FY 1993. SMI outlays rose 10.1 percent to $59.7 billion.

Both the HI and SMI Trust Fund income to outgo ratios decreased in FY 1994. The HI Trust Fund ratio decreased one percent, taking in $1.03 for each $1.00 outlayed. The SMI Trust Fund ratio decreased eleven percent, taking in $0.96 for each $1.00 outlayed.



Medicare Benefit Outlays

Benefit payments accounted for 98.4 percent of the total $162.1 billion in outlays. HI benefit payments rose 11.9 percent, SMI benefits 10.7 percent. Inpatient hospital services now account for about 80 percent of HI benefits. Hospital payment growth was driven by both increased hospital admissions and higher costs per admission. Spending for skilled nursing facility care, home health care, and hospice care continued to rise at a much faster rate, but these services constitute a much smaller portion of total HI outlays.

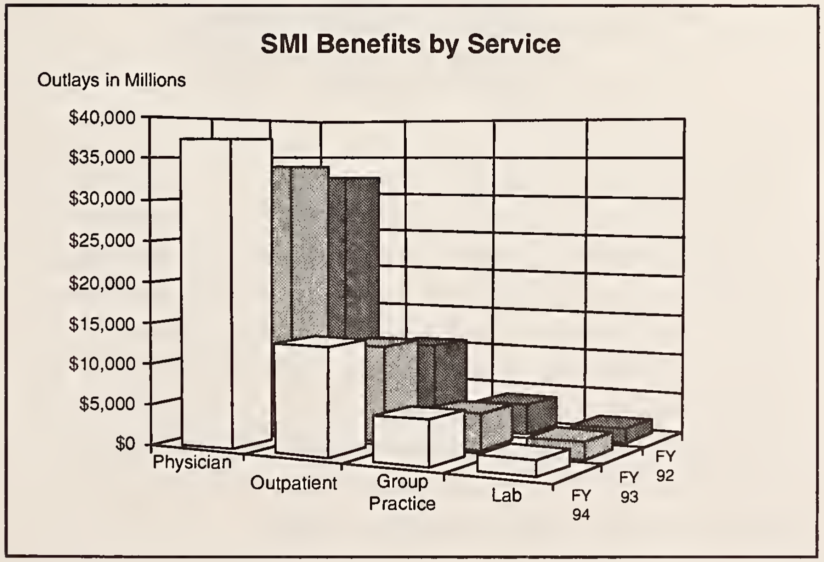


Of the $10.8 billion increase in HI benefits, inpatient hospital spending accounted for $5.9 billion or 55 percent. Home health spending accounted for only 11.8 percent of total spending but 24 percent of the FY 1994 increase.

SMI benefits grew at a more modest 10.7 percent, but still far outpaced general inflation. Physician services, the largest component of SMI spending, grew 8.8 percent and accounted for nearly 54 percent of the FY1994 increase.

Though only constituting 23 percent of SMI benefits, payments for outpatient services accounted for nearly 32 percent of FY 1994 SMI growth.

HI benefits per enrollee rose 9.5 percent to $2,796. However, less than 22 percent of HI enrollees received benefits in FY 1994—thus, spending per enrollee receiving services was much higher: $13,804. SMI benefits per enrollee increased 8.7 percent to $1,658. Spending per enrollee receiving services was $2,000.



Medicare Administrative Expenses

HCFA's total administrative expenses were $2.76 billion in FY 1994, a 2.3% increase from FY 1993. Of this amount, total Medicare administrative expenses in FY 1994 were $2.62 billion: 75.5% for HCFA Program Management, 17.1% for Social Security Administration and other Federal agencies providing Medicare program support, and 7.4% for Peer Review Organizations.

Peer Review Organizations (PROs)

The PRO program, initiated in 1984, is the primary Federal effort to monitor the quality of care provided to Medicare beneficiaries. The PRO program's mission is to ensure that health care services are medically necessary, appropriate, provided in a proper setting, and are of acceptable quality.

PROs carry out their mission primarily by reviewing the medical records of a statistical sample of Medicare inpatient and outpatient hospital cases. In FY 1994, HCFA administered 53 PRO contracts: one per State, the District of Columbia, the Virgin Islands, and Puerto Rico.

Under Federal budget rules, the PRO program is defined as "mandatory" rather than as "discretionary" because, like

Medicare benefits, PRO costs are financed directly from the Trust Funds and are not subject to the annual appropriations process. PRO Trust Fund outlays in FY 1994 totaled $195 million, $19 million or 8.9 percent less than in FY 1993. The decrease in PRO outlays is largely attributable to full implementation of the new Health Care Quality Improvement Program (HCQIP) Scope of Work in PRO contracts.

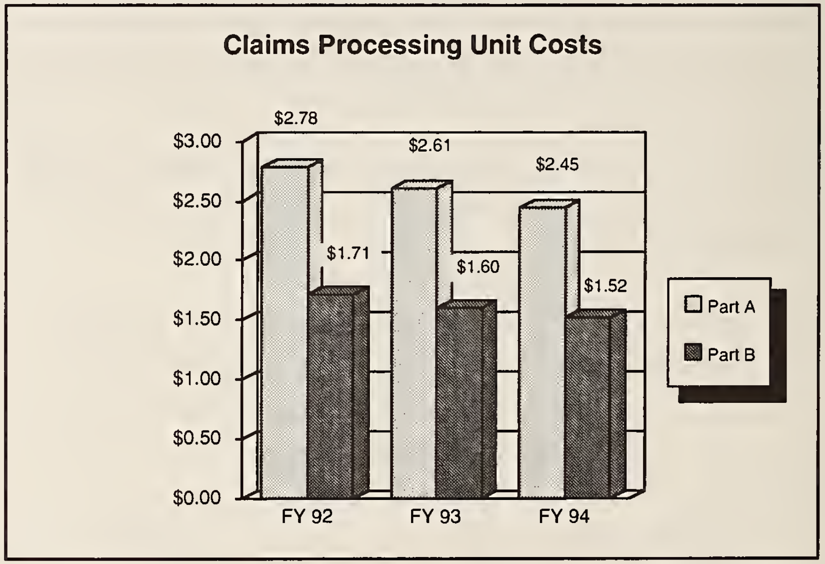
This new HCQIP strategy is being refined by HCFA to better ensure Medicare quality of care by replacing the current system of reviewing individual medical records with statistical and epidemiological analyses of patterns of care and outcomes. In FY 1994, HCFA continued to use the experience of five pilot study PROs to chart the implementation strategy for this ambitious new undertaking. National implementation will begin in FY 1995.

Program Management

In FY 1994, 81 HCFA contractors provided local administration of the Medicare program. **Medicare contractors** review and pay benefit claims, respond to beneficiary and provider inquiries, audit providers, conduct hearings and appeals, and carry out other claims-related work. There are 46 fiscal intermediaries handling HI (and some SMI) and 35 carriers handling SMI.

In FY 1994, Medicare contractor administrative expenditures held steady at $1.5 billion. At the same time, the processed workload for Part A bills increased by 10 percent, and by 7 percent for Part B claims.

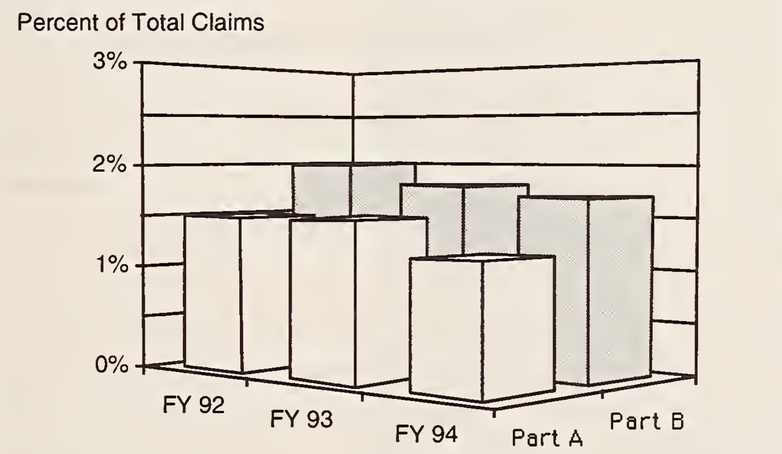
HCFA continued to bridge the growing gap between workload and contractor funding through unit cost reduction. Contract negotiations, special initiatives, and contractor evaluation policies stressed the importance of lowering unit costs in individual contracts and reducing variation among contractors.



As in FY 1993, target unit costs were set that incorporated industrial engineering study results demonstrating that much of the variation in contractor unit costs is attributable to differences in contractor claims mixes. By building a workload complexity index into target unit cost calculations, HCFA was able to reduce variation by more accurately portraying each contractor's costs relative to the national average. Also, by stressing the importance of electronic claims submission, HCFA was able to reduce unit costs overall.

As claims processing costs decreased, the end-of-year backlog pending as a percent of claims decreased for Part A from 1.5 percent to 1.2 percent and from 1.8 percent to 1.7 percent for Part B.

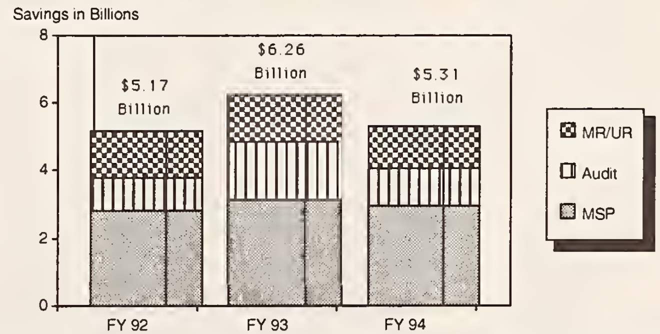
Claims Processing Backlog, End-of-Year



The Medicare contractors carry out a range of activities collectively known as "payment safeguards" to prevent and recover inappropriate Medicare benefit payments. Over the past several years, these activities have returned significant savings to the Trust Funds. Payment safeguards include:

- Medicare Secondary Payer (MSP)—identification of instances where other insurance should be primary.
- Audits of Medicare providers.
- Medical Review and Utilization Review (MR/UR).
- Fraud and abuse detection.

Payment Safeguards Savings

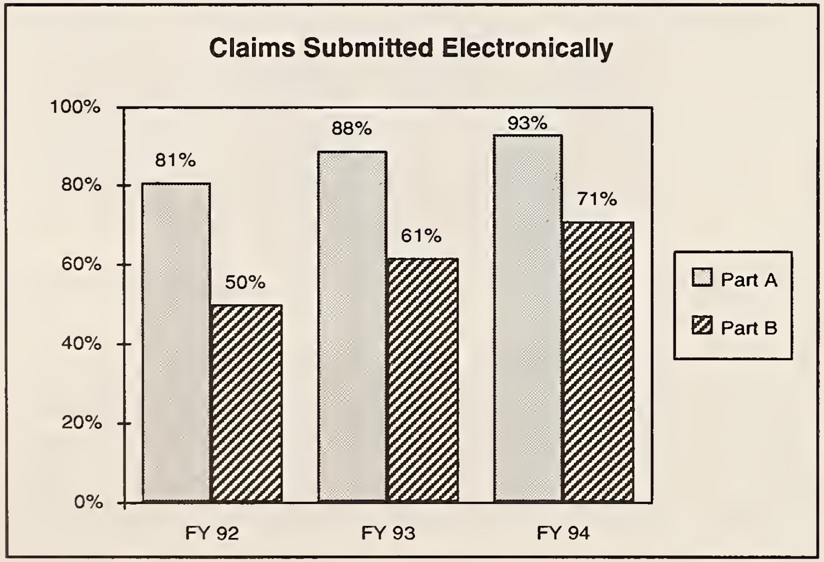


In FY 1994, HCFA continued to evolve an MR/UR program which emphasized the involvement of providers in local MR policy development in order to prevent the delivery of inappropriate services rather than denying billed services. A methodology to measure the effectiveness of MR is being developed.

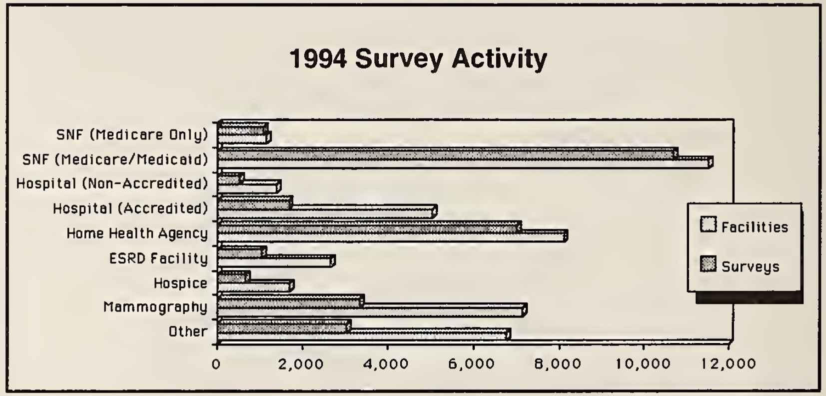
The magnitude of Medicare payment safeguard savings illustrates that funding of payment safeguards is a sound investment. Each appropriated payment safeguard dollar leads to savings of many more benefit dollars.

In addition to payment safeguards, HCFA invested $58 million in Medicare Contractor productivity investments. These include initiatives that sustained activities directly in support of the transition to the Medicare Transaction System such as:

- Direct efforts to fund systems alternatives and software development.
- Efforts to consolidate the Shared Claims Processing Systems.



The mission of the **State Survey and Certification** program is to ensure that Medicare service providers and suppliers comply with Federal health, safety, and program standards. To meet this goal, HCFA administers agreements with State survey agencies to conduct onsite facility inspections. Only certified providers and suppliers are eligible for Medicare payments. A companion Medicaid State certification program is funded through the Medicaid appropriation.



Total spending in FY 1994 was $165 million. In FY 1994, State surveyors conducted 28,966 inspections and found 1,910 facilities out of compliance with basic Medicare conditions of program participation for a condition-level deficiency rate of 7 percent, the same rate as in 1993. 19,187 facilities were cited for less serious, standard-level deficiencies in FY 1994. These facilities represented a 66 percent standard-level deficiency rate, slightly higher than FY 1993's 65 percent rate.

While most facilities rectified deficiencies through verified completion of corrective action plans, 72 others were involuntarily terminated from Medicare in FY 1994. Additionally, many providers facing the threat of termination chose to voluntarily withdraw from Medicare participation.

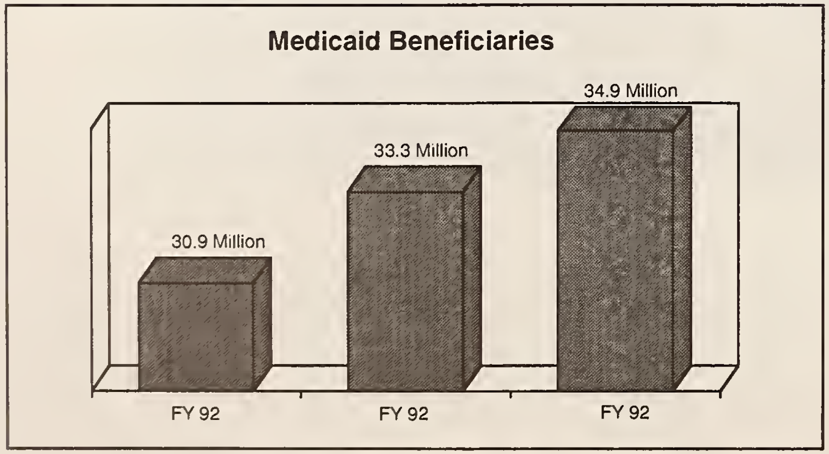
Chapter 4

Medicaid

Program Profile

Medicaid is the means-tested health care program for low-income Americans, administered in partnership by States and the Federal government. Enacted in 1965 as Title XIX of the Social Security Act, Medicaid was originally legislated to provide medical assistance to welfare recipients. Over the years, however, Congress incrementally expanded Medicaid well beyond the traditional welfare population. Today, Medicaid is the primary source of health care for a much larger population of medically vulnerable Americans, including—

- poor families,
- the blind and disabled, and
- low-income elderly, disabled, and mentally retarded persons requiring long-term care.



One U.S. citizen in eight was covered by Medicaid in fiscal year 1994.

Under Medicaid's division of responsibilities, HCFA provides matching payment grants to State governments.

- State medical assistance payments are matched according to a formula relating each State's per capita income to the national average. In FY 1994, the Federal matching rate ranged from 50 to 79 percent, with a national average of 57 percent.
- Federal matching rates for various State and local administrative costs are set by statute, and in 1994 averaged 56 percent.

Medicaid grants are funded by Federal general revenues provided to HCFA through the annual Labor/HHS/Education Appropriations Act. There is no cap on Federal matching payments to States.

States set eligibility, coverage, and payment standards within broad Federal guidelines that include—

- Providing coverage to persons receiving Aid to Families with Dependent Children and Supplemental Security Income, to the medically needy, to pregnant women, to young children, to low-income Medicare beneficiaries, and to certain other groups; and

- Covering 13 mandatory services, including hospital treatment, laboratory tests, family planning, nursing facility services, and health screening for children under age 21.

State governments have a great deal of programmatic flexibility to tailor their Medicaid programs to individual State circumstances and priorities. Accordingly, there is a wide variation in the services offered by the States. For example, 31 State Medicaid programs cover psychologist services, 50 cover dental services, and 15 cover services provided in Christian Science sanitoria.

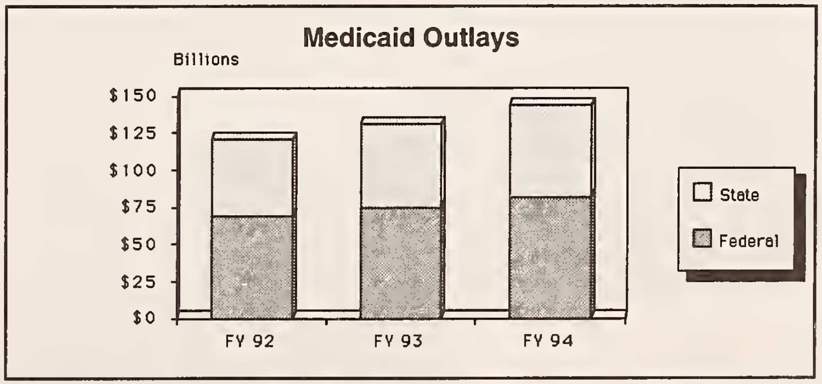
Medicaid helps reduce infant mortality and improve maternal and infant health by bringing more eligible pregnant women into risk-specific health care and more infants into early health supervision. States can pursue these goals by expanding eligibility, streamlining eligibility processes, conducting outreach, improving provider recruitment and retention, and adding new service delivery options or enhancements.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program is a preventive and comprehensive health program for Medicaid eligible individuals under age 21. It creates a conceptual framework under which Medicaid eligible children can receive regular preventive health screenings and a range of follow-up services that may be broader than those available to Medicaid eligible adults.

Medicaid serves at least 40 percent of all persons living with AIDS and up to 90 percent of all children with AIDS, and is the largest single payer of direct medical services for persons living with AIDS. Most adults with AIDS or HIV-related illnesses who qualify for Medicaid do so because they are disabled, have low income, and have limited assets. Women and children who are not considered disabled may qualify for Medicaid if they receive cash benefits under AFDC, or may qualify as an impoverished pregnant woman or child.

FY 1994 Highlights

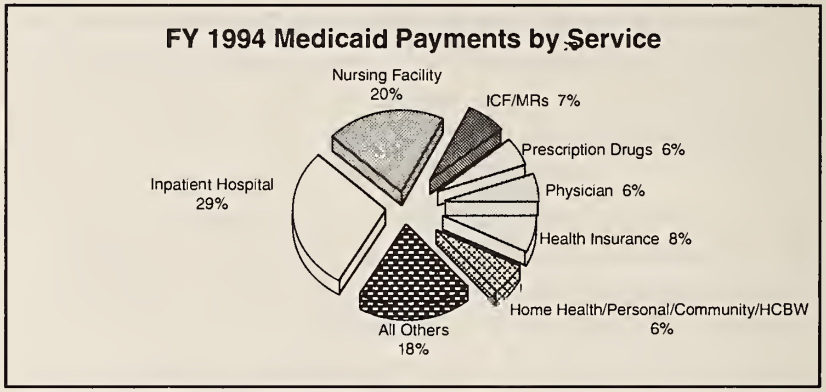
The Medicaid program experienced a slowdown in the growth of its outlays in FY 1994. This slowdown is due in part to several interacting factors: (1) A general slowdown in the rate of health care price inflation; (2) aggressive use of managed care and utilization management by States; (3) continued limits on the ability of States to use tax and donation arrangements to leverage Medicaid funding; (4) limits on disproportionate share hospital expenditures (DSH) that took effect in FY 1993; and (5) a strengthening economy.



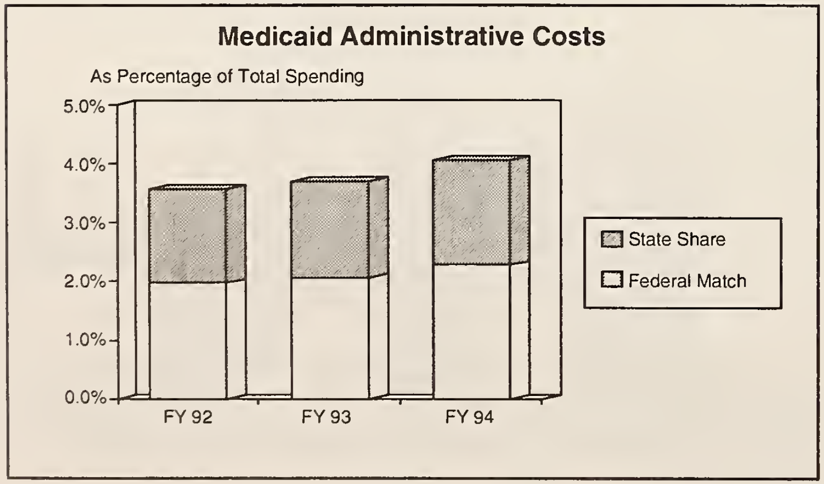
Total Medicaid outlays in FY 1994 were $143.2 billion—$82.0 billion in Federal outlays and $61.2 billion in State outlays.

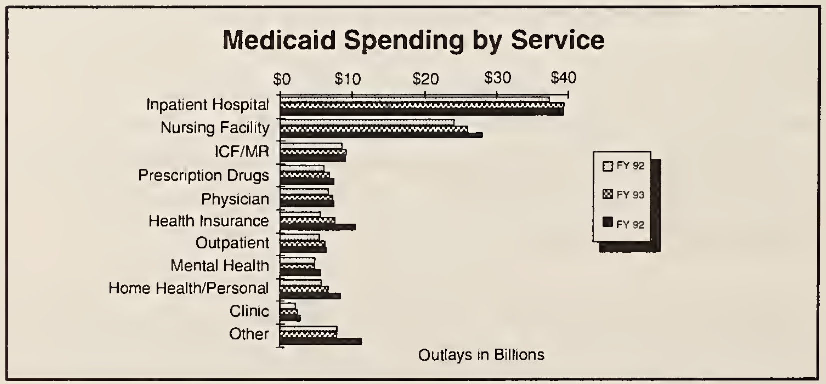
Total outlays in FY 1994 were $11.4 billion higher than in FY 1993, an 8.7 percent increase. Federal outlays alone increased $6.3 billion, an 8.3 percent increase over FY 1993. Federal outlays have increased 21 percent between FY 1992 and FY 1994.

Medicaid outlays are divided into two components: administrative and medical assistance payments. In FY 1994, administrative outlays were $5.8 billion — only 4.1 percent of the Medicaid outlays. However, total medical assistance outlays reported by the States amounted to $137.6 billion. Medical assistance outlays increased 9.4 percent over FY 1993. Inpatient hospital charges, which accounted for 32 percent of total medical assistance outlays in FY 1993, declined $41 million in FY 1994. Most of this decrease resulted from: (1) delays in disproportionate share hospital payments into FY 1995; (2) the cessation of DSH payments in statewide managed care waivers; and (3) the shifting of regular inpatient costs to capitated managed care programs. Health insurance payments, which accounted for only 8 percent of total medical assistance outlays in FY 1994, made up nearly 23 percent of the growth from FY 1993.



Children comprised about 48 percent of the Medicaid population, but accounted for only 15 percent of Medicaid outlays. In contrast, the elderly and disabled made up over one-fourth of the Medicaid rolls, but accounted for about 60 percent of program spending.





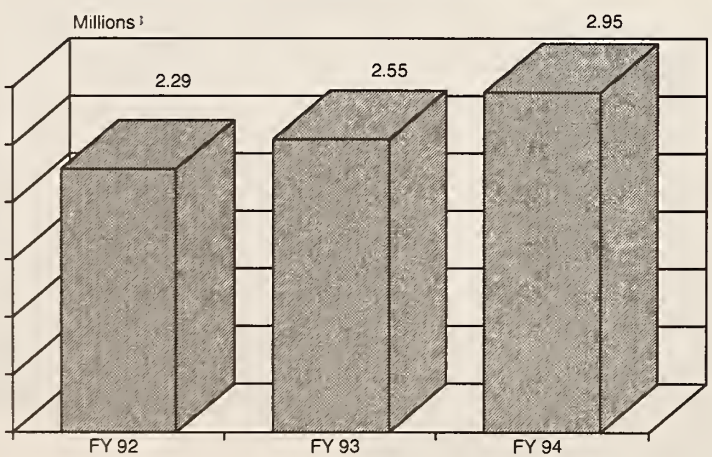
Chapter 5

Managed Care

Medicare Managed Care: Program Profile

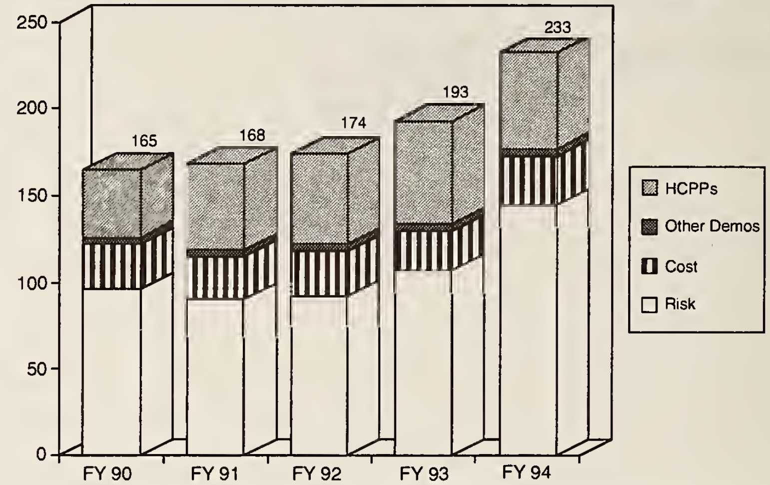
In general, a managed care organization consists of its own providers or a network of health care providers (physicians, hospitals, skilled nursing facilities, etc.) that agrees to arrange for health care services to its members. Any individual (Medicare covered or Non-Medicare eligible) can join a managed care organization. To become a member of a managed care organzation, an individual must agree to conform with the plan's rules, and depending upon the insurance coverage contracted for, the individual may be required to pay certain deductibles or co-payment amounts.

Medicare Managed Care Enrollment



At present, HCFA contracts with Health Maintenance Organizations (HMOs), Competitive Medical Plans (CMPs), Health Care Prepayment Plans (HCPPs) and certain demonstration projects as Medicare managed care organizations. In addition, Preferred Provider Organizations (PPOs) and point-of-sale organizations are included under the umbrella of managed care organizations by the health care industry. Many people find that managed care organizations provide additional services/ benefits at little or no additional cost. Because HCFA pays most premiums for beneficiaries who choose to use managed care organizations, medical expenses are more predictable and additional beneficiary out-of-pocket expenses are kept to a minimum.

Medicare Contracts with Managed Care Organizations

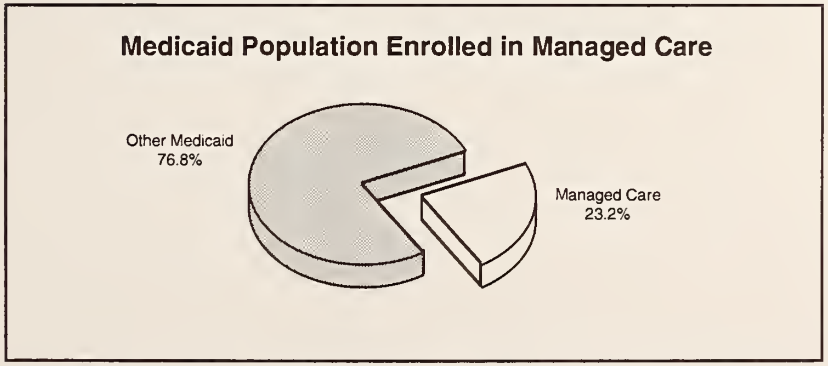


Medicare managed care is growing. An increasing number of people coming into the Medicare program are choosing managed care. Since FY 1992, the number of Medicare enrollees in managed care plans has increased 29%. HCFA has also seen

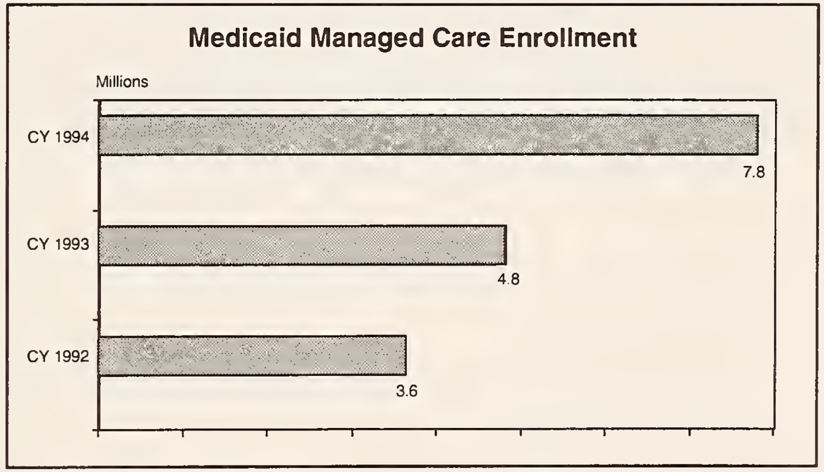
an increased interest from health care entities in contracting with HCFA for the delivery of Medicare managed care services. This trend is evident as the number of Medicare contracts with managed care organizations has increased from 165 in FY 1990 to 233 contracts in FY 1994. Of the $162.1 billion in outlays for Medicare in FY 1994, managed care outlays accounted for $11.7 billion. The growth of Medicare managed care creates new challenges for HCFA, particularly in the areas of enforcement activities (including investigations, intermediate sanctions, and civil monetary penalties) and quality assurance.

Medicaid Managed Care: Program Profile

Many States are pursuing managed care as an alternative to the fee-for-service system for their Medicaid programs. Managed health care provides several advantages for Medicaid recipients, such as: enhanced continuity of care, improved preventive care, and prevention of duplicative and contradictory treatments and/or medications.



HCFA and the States have worked in partnerships to offer managed care to Medicaid recipients. Medicaid law provides for two kinds of waivers of existing statutes to allow for the implementation of managed care — state health reform waivers (section 1115 of the Social Security Act) and freedom of choice waivers (section 1915(b) of the Social Security Act). By the end of calendar year 1994, seven state health reform and 73 freedom of choice waiver programs had been approved by HCFA.



Forty-five States have managed care available to Medicaid recipients through contracts with health maintenance organizations, prepaid health plans, primary care case managers, and/or health insuring organizations. The number of Medicaid recipients enrolled in managed care grew 62% from 1993 to 1994. In FY 1994, 23% of all Medicaid recipients were enrolled in managed care — up from 14% in the previous year.

While managed care programs have been successful in many States, the programs have presented new challenges to HCFA and the States, especially in the areas of quality and data collection. In 1994, HCFA made significant progress toward meeting these challenges. HCFA's quality improvement strategy includes developing meaningful information on quality for the purpose of program monitoring, consumer information, and continuous quality improvement by providers of care.

In 1994, HCFA continued the Quality Assurance Reform Initiative (QARI), which is an attempt to provide States with guidance in the development of internal, external, and continuous quality improvement programs. In July 1993, HCFA published A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States. In 1994, HCFA performed a study to determine how the States were using A Guide for States. In addition, HCFA began working with the National Committee on Quality Assurance (NCQA) and other public and private groups to develop performance measures for Medicaid, and continued efforts to refine these performance measures. A publication entitled Health Care Quality Improvement Studies in Managed Care Settings was published by NCQA under contract with HCFA. Future plans include updating the Guide for States. HCFA is committed to working with the States to identify and collect meaningful data and to use it to monitor performance of managed care programs.

Financial Statements and Notes

COMBINED STATEMENT OF FINANCIAL POSITION
AS OF SEPTEMBER 30, 1994

	(Dollars in Millions)	
	FY 1994	**FY 1993 Restated**
ASSETS		
Entity Assets:		
Intragovernmental Assets:		
Fund Balances *(Note 2)*	$27,289	$14,188
Accounts Receivable, Net	1	
Governmental Assets:		
Accounts Receivable, Net *(Note 3)*	2,538	3,003
Advances and Prepayments	335	2,411
Property and Equipment, Net	26	29
Total Entity Assets	**$30,189**	**$19,631**
Non-Entity Assets:		
Intragovernmental Assets:		
Fund Balances *(Note 2)*	$917	$1
Interest Receivable	3,107	3,113
Investments *(Note 4)*	150,204	149,346
Governmental Assets:		
Accounts Receivable, Net *(Note 3)*	480	230
Total Non-Entity Assets	**$154,708**	**$152,690**
TOTAL ASSETS	**$184,897**	**$172,321**

(Dollars in Millions)	FY 1994	FY 1993 Restated
LIABILITIES		
Liabilities Covered by Budgetary Resources:		
Intragovernmental Liabilities:		
Accounts Payable *(Note 5)*	$29	$5
Employment Tax Liability *(Note 5)*	3,681	3,336
Liabilities for Loan Guarantees	28	34
Governmental Liabilities:		
Accounts Payable *(Note 5)*	27,590	14,160
Suspense Accounts Deposit Funds	2	5
Interest Payable		1
Accrued Payroll and Benefits	6	4
Deferred Revenue		184
Other Governmental Liabilities *(Note 6)*	299	
Total Liabilities Covered by Budgetary Resources	**$31,635**	**$17,729**
Liabities not Covered by Budgetary Resources:		
Intragovernmental Liabilities:		
Accounts Payable	$6	
Uncollected Revenue due Treasury *(Note 6)*	159	$161
Governmental Liabilities:		
Accrued Leave	18	18
Other Governmental Liabilities *(Note 6)*	179	540
Total Liabilities not Covered by Budgetary Resources	**$362**	**$719**
TOTAL LIABILITIES	**$31,997**	**$18,448**
NET POSITION *(Note 7)*		
Balances:		
Unexpended Appropriations	$153,078	$154,394
Invested Capital	26	31
Less: Future Funding Requirements	204	552
TOTAL NET POSITION	**$152,900**	**$153,873**
TOTAL LIABILITIES & NET POSITION	**$184,897**	**$172,321**

The accompanying notes are an integral part of these statements.

COMBINED STATEMENT OF OPERATIONS AND CHANGES IN NET POSITION
FOR THE PERIOD ENDING SEPTEMBER 30, 1994

(Dollars in Millions)

	FY 1994	FY 1993 Restated
REVENUE AND FINANCING SOURCES		
Direct Appropriations Expended	$86,670	$74,213
Employment Tax Revenue *(Note 8)*	91,682	82,792
SMI Premiums Collected *(Note 9)*	16,895	14,683
Federal Matching Contributions *(Note 9)*	38,355	44,227
Revenue From Sales of Goods/Services		
CLIA User Fees	31	34
Intragovernmental	4	5
Interest & Penalties (Non-Fed)	3	24
Interest (Fed)	12,702	12,550
Other Revenue and Financing Sources *(Note 10)*	3,189	1,339
Uncollected Revenue		(48)
Trust Fund Draws	2,109	2,044
Revenue Transferred to Program Management	(2,109)	(2,044)
Transfers to FDA Pursuant to P.L. 103-50		(1)
Less: Collections For Principal Repayments Transferred To The Federal Financing Bank	6	26
Taxes and Receipts Transferred To the Treasury or Other Agencies		57
Total Revenues and Financing Sources	**$249,525**	**$229,735**
EXPENSES		
Program or Operating Expenses		
Medicare Benefit Payments *(Note 11)*	$170,544	$135,681
Medicaid Benefit Payments *(Note 11)*	86,670	74,189
Administrative Expenses *(Notes 11 and 12)*	2,760	2,697
Other *(Note 11)*	41	26
Depreciation and Amortization *(Note 11)*	5	5
Interest Expense		11
Other Expenses *(Notes 11 and 13)*	(355)	(1,701)
Total Expenses	**$259,665**	**$210,908**
Excess (Shortage) of Revenue/Financing Sources Over Total Expenses	**(10,140)**	**18,827**
Net Position, Beginning Balance	$157,378	$125,377
Plus (Minus) Prior Period Adjustments *(Note 14)*	(3,505)	
Net Position, Beginning Balance as Restated	153,873	125,377
Excess (Shortage) of Revenues/Financing Sources Over Total Expenses	(10,140)	18,827
Plus (Minus) Non-Operating Changes *(Note 15)*	9,167	9,669
Net Position, Ending Balance	**$152,900**	**$153,873**

The accompanying notes are an integral part of these statements.

NOTE 1: Summary of Significant Accounting Policies

Reporting Entity

The Health Care Financing Administration (HCFA) is considered a separate reporting entity of the Department of Health and Human Services (DHHS) for financial reporting purposes. The financial statements, required by the Chief Financial Officers Act of 1990, are prepared from HCFA's accounting records in accordance with the form and content as specified by the Office of Management and Budget (OMB) in OMB Bulletin 93-02 and subsequent issuances and by DHHS's and HCFA's accounting policies, which are summarized in these footnotes.

The financial statements include the accounts of all funds administered by HCFA which are discussed below.

Medicare Hospital Insurance (HI)

Medicare contractors are paid by HCFA as our agents to receive and process Medicare claims for hospital inpatient services, hospice and certain skilled nursing and home health services. Payments made by the Medicare contractors for these services are withdrawn from the HI trust fund. This portion of the statements includes HI trust fund activities administered by the U.S. Department of Treasury.

Medicare Supplementary Medical Insurance (SMI)

Medicare contractors are also paid by HCFA to process Medicare claims for physicians, medical suppliers, hospital outpatient services and rehabilitation, chronic renal disease, rural health clinic, and certain skilled nursing and home health services. Payments made by the Medicare contractors for these services are withdrawn from the SMI trust fund. This portion of the statements includes SMI trust fund activities administered by the U.S. Department of Treasury.

Medicaid

Medicaid, the health care program for low-income Americans, is administered in partnership by the States and the Federal government. Grant awards prepared by HCFA's Medicaid Bureau limit the advances that can be drawn by the States to cover current expenses. The grant awards, prepared at the beginning of each quarter and amended as necessary, are an estimate of the Federal government's share of States' Medicaid costs. At the end of each quarter, States submit a report of their expenses net of recoveries for the quarter and subsequent grant awards are issued for the difference between approved expenses reported for the period and the grant awards previously issued.

The financial statements include the approved expenses reported by States for the first two quarters of FY 1994 and an estimate for the third and fourth quarter expenses. The estimate is an accrued amount based on the cash advanced to States in the third and fourth quarter to cover their expenses which will be submitted for approval after September 30, 1994.

Program Management

The Program Management appropriation provides HCFA with the capacity to administer and oversee the Medicare and Medicaid programs. The funds for this activity are provided primarily by transfers from the HI and SMI trust funds. In addition, user fees collected from Health Maintenance Organizations seeking Federal qualification and reimbursement from other agencies for services performed for them by HCFA are credited to this appropriation. During FY 1994, the Payments to the Health Care Trust Funds appropriation paid the Medicare Trust Funds $100,962,142 to cover the Medicaid program's share of HCFA administrative costs. HCFA's cost allocation system determines the distribution of funds between the funding sources. All expenses chargeable to the Program Management appropriation, except HMO user fees and reimbursement from other agencies, are allocated to the Medicare HI and SMI and the Medicaid programs and are reported to those programs in the Supplemental Section of this report.

Funds are obtained from the HI and SMI trust funds as cash is needed to pay for Program Management appropriation expenses. During FY 1994, a total of $2,109,679,508 was obtained from the trust funds to cover cash outlays. Of this amount, $1,853,153,018 was needed to pay for expenses incurred against current year obligations and $256,526,490 was needed for expenses incurred against prior year obligations.

All Others

The following accounts are reported in the "All Others" column of the financial statements by activity.

1) SECA Credits

The Self-Employment Contribution Act provides for tax credits from the general funds of the Treasury. These credits represent the difference between the statutory SECA and the actual tax rate paid by the self-employed. The amounts reported in FY 1994 are adjustments to tax years 1984 through 1989. For purposes of financial statement presentation, the revenue and expenses for this account are reported only in the Medicare HI and SMI accounts.

2) Payments to the Health Care Trust Funds

The Social Security Act provides for payments to the Health Care Trust Funds for Supplementary Medical Insurance (appropriated funds to provide for federal matching of SMI premium collections), Hospital Insurance for the Uninsured, and Federal Uninsured Payments. In addition, appropriated funds are provided to cover the Medicaid program's share of HCFA administrative costs. For purposes of financial statement presentation, the revenue and expenses of this appropriation are reported only in the Medicare HI and SMI accounts.

3) Suspense

Agencies are required to deposit receipts expeditiously. Unidentified collections are deposited into a suspense account for immediate availability to Treasury while HCFA researches the actual application of funds.

4) Miscellaneous Fines, Penalties, and Forfeitures

Civil monetary penalties and Freedom of Information administrative fees are assessed on overdue payments.

5) Interest Receipts

Interest resulting from debt collection is deposited to Treasury miscellaneous receipt accounts.

6) General Fund Receipts

The Freedom of Information Act provides for the proceeds from the sale of publications to be deposited to Treasury miscellaneous receipt accounts along with other miscellaneous recoveries and refunds.

7) Health Maintenance Organization (HMO) Loan Program

The Public Health Service's HMO program was transferred to HCFA in 1985. Included in this transfer was the HMO Loan and Loan Guarantee Fund, originally established to provide working capital to HMOs during their initial periods of operations and to guarantee loans made by private lenders to HMOs.

The last loan commitments were made in FY 1983. Direct loans to HMOs were sold, with a guarantee, to the Federal Financing Bank (FFB). The FFB purchase proceeds were then used as capital for additional direct loans. Therefore, the fund operates as a revolving fund. Currently, HCFA collects principal and interest payments from HMO borrowers, and in turn pays the FFB.

8) Clinical Laboratory Improvement Amendments (CLIA)

The Clinical Laboratory Improvement Amendments of 1988 marked the first comprehensive Federal effort to regulate medical laboratory testing. HCFA and the Public Health Service share responsibility for the CLIA program, with HCFA having the lead responsibility for financial management.

Fees for registration, certificates and compliance determination of all U.S. clinical laboratories are collected to finance the program. Therefore, like the HMO loan program, the CLIA fund operates as a revolving fund.

9) Program Management

Activities related to HMO user fees and reimbursements from other agencies are reported here. The balance of the Program Management appropriation data is cost allocated among the HI and SMI Trust Funds and Medicaid and is presented in the Supplemental Information section of the Financial Report.

10) Income Tax on Old Age and Survivors and Disability Insurance (OASDI)

This account is presented for the first time on HCFA's financial statements in FY 1994. The Omnibus Budget Reconciliation Act of 1993 increased the maximum percentage of OASDI benefits that are subject to Federal income taxation under certain circumstances from 50 percent to 85 percent for taxable years beginning in 1994. The revenues resulting from this increase are transferred to the HI trust fund.

For purposes of financial statement presentation, the revenues and expenses for this account are reported only in the Medicare HI and SMI accounts.

Basis of Accounting

Transactions are recorded on both an accrual and cash method. Under the accrual method, expenses are recognized when a liability is incurred without regard to the payment of cash. Under the cash method, expenses are recognized when cash is outlayed.

The Medicare Program uses the cash method to record benefit payments disbursed during the fiscal year, supplemented by the accrual method to estimate the value of benefit payments incurred but not yet paid as of the fiscal-year end. Revenues are recognized when earned without regard to receipt of cash.

The cash method is used in the Medicaid Program to record draws by the States to cover current quarter expenses, supplemented by the accrual method to estimate the value of expenses net of recoveries not yet reported to HCFA as of the fiscal-year end. Revenues are recognized as appropriated capital is used.

Budgetary accounting facilitates compliance with legal constraints and controls over the use of Federal funds. HCFA uses the Government's Standard General Ledger account structure.

Funds with the U.S. Treasury and Cash

HCFA does not maintain cash in commercial bank accounts. Cash receipts and disbursements are processed by the U.S. Treasury with the exception of third party drafts which are primarily used to reimburse employees for travel expenses. Funds with Treasury are primarily available to pay current liabilities. Cash balances held by Treasury are reconciled each month to control records maintained by HCFA.

Investments

HCFA is required by Section 201(d) of the Social Security Act to invest HI and SMI trust fund holdings not necessary to meet current expenditures in "interest bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States." These investments are carried at amortized cost as determined by the U.S. Treasury. Interest income is compounded semi-annually (June and December) and has been adjusted to include an accrual for interest earned from July 1 to September 30.

Retirement Plan

HCFA's employees participate in the Civil Service Retirement System (CSRS) or the Federal Employees Retirement System (FERS). Under CSRS, HCFA makes matching contributions equal to 7 percent of pay. HCFA does not report CSRS assets, accumulated plan benefits, or unfunded liabilities, if any, applicable to its employees. Reporting such amounts is the responsibility of the Office of Personnel Management.

Most employees hired after December 31, 1983 are automatically covered by FERS. Employees hired prior to January 1, 1984, can elect either to join FERS or remain in CSRS. A primary feature of FERS is that it offers a savings plan to which HCFA is required to contribute 1 percent of pay and match employee contributions up to an additional 4 percent of pay.

For employees covered by FERS, HCFA also contributes the employer's matching share of Social Security taxes.

Estimation of Obligations Related to Cancelled Appropriations

As of September 30, 1994, HCFA has canceled over $57 million in obligations to FYs 1989 and prior in accordance with Public Law 101-510. Based on the payments made in FYs 1991 through 1994 related to canceled appropriations, HCFA anticipates an additional $4.7 million will be paid from future current year funds for canceled obligations.

Comparative Data

Comparative Data for the prior year has been presented. However, the required presentation of the FY 1994 Financial Statements is substantially different than the required presentation of the FY 1993 Financial Statements (which have been restated to reflect the accounting changes discussed in the following paragraph). Where individual like data could not be compared, totals were compared.

Accounting Changes

In previous fiscal years, the uncollected portion of General/Trust Fund Miscellaneous Receipts has been reported as part of Equity. In FY 1994, the U.S. Treasury, with the Standard General Ledger Board's approval, required the uncollected portion of Miscellaneous Receipts to be reported as a payable to the U.S. Treasury. In addition, a liability and an Equity change were reported for the wage certification issue discussed in Note 8.

In FY 1994, Medicaid program and audit disallowances and deferrals are reported at the value HCFA expects to pay based on historical data. In previous fiscal years, the full value of the disallowances and deferrals was reported and the actual amount expected to be paid was disclosed in a footnote.

The expenses reported for the Medicaid program reflect the actual States' expenditures that are available for the first and second quarter of FY 1994. In addition, an accrual for the States' third and fourth quarter expenditures was developed from the cash advances the States drew to cover their expenses in these quarters. In previous years, this accrual was developed from the grant awards which authorize the advance draws and are usually in excess of the advances.

Limitations to the Financial Statements

The financial statements have been prepared to report the financial position and results of operations of HCFA as required by the Chief Financial Officers Act of 1990.

In accordance with guidance from the Office of Management and Budget, the financial statements have been prepared from HCFA's general ledger and subsidiary reports and supplemented with financial data prepared by the U.S. Treasury. The statements are different from the financial reports used to monitor and control budgetary resources (which also are prepared from the general ledger and subsidiary reports) due to the inclusion of the U.S. Treasury financial data and the presentation of the cost allocation of HCFA's Program Management appropriation.

The statements should be read with the realization that they are prepared by an independent entity of the Federal government, that liabilities not covered by budgetary resources cannot be liquidated without the enactment of an appropriation, and that the payment of all liabilities other than for contracts can be nullified by the entity.

Note 2: Fund Balances (Dollars in Millions)

Entity Fund Balances	Obligated	Unobligated		Total
		Available	Restricted	
Trust Funds				
HI Trust Fund Balance	$(80)			$ (80)
SMI Trust Fund Balance	(580)			(580)
Revolving Funds				
HMO Loan (1)	1	$9		10
CLIA (1)	5	19		24
Appropriated Funds				
Medicaid	4,143	13,033		17,176
Payments to the Health Care Trust Funds (1)			$10,737	10,737
Other Fund Types				
HCFA Suspense Account (1)		2		2
Total Entity Fund Balances	**$3,489**	**$13,063**	**$10,737**	**$27,289**

(1) These funds balances are reported in the Supplemental Information Section under "All Others" on the Statement of Financial Position by Activity.

Non-Entity Fund Balance
The U.S. Treasury reported Trust Fund balances of $1 million in SMI and $916 million in HI to HCFA for inclusion in our financial statement.

Note 3: Accounts Receivable (Dollars in Millions)

	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Other	Combined Total
Entity/Governmental						
Accounts Receivable	$2,605	$1,326	$3,931	$61	$16	$4,008
Less: Allowance for Uncollectible Accounts	851	600	1,451	19		1,470
Net Entity/Governmental A/R	**$1,754**	**$726**	**$2,480**	**$42**	**$16**	**$2,538**
Non-Entity/Governmental						
Accounts Receivable	$96	$276	$372		$212	$584
Less: Allowance for Uncollectible Accounts	10	41	51		53	104
Net Non-Entity Governmental A/R	**$86**	**$235**	**$321**		**$159**	**$480**
Total Governmental A/R	**$2,701**	**$1,602**	**$4,303**	**$61**	**$228**	**$4,592**
Less: Total Allowance for Uncollectible Accounts	**861**	**641**	**1,502**	**19**	**53**	**1,574**
Net Total Governmental A/R	**$1,840**	**$961**	**$2,801**	**$42**	**$175**	**$3,018**

The accounts receivable were primarily reported from data received by the Medicare contractors. The majority of these receivables are due to overpayments to providers, beneficiaries, physicians and suppliers, and to those claims where Medicare should be the secondary rather than the primary payer (Medicare Secondary Payer-MSP-claims). Only those MSP claims that have been identified to a debtor and for which a collectible amount has been determined are included in the accounts receivable. An additional 1.6 million claims are being researched as potential MSP accounts receivable and have not been reported due to the uncertain nature of the leads.

The MSP portion of the accounts receivable as reported by the Medicare contractors may be impacted by the court case, HIAA/BCA V. SHALALA. On May 13, 1994, the District of Columbia Court of Appeals ruled that (1) third party administrators are not entities responsible for payment and Medicare may not seek to recover from them and that (2) Medicare is bound by timely filing requirements imposed by third party payers. As of the ruling date, MSP receivables affected by the case amounted to $150 million. Therefore, the accounts receivable reported as of September 30 are potentially overstated. It is unclear if any refunds of collections affected by the case will have to be made by HCFA. The Agency is currently seeking judicial and legislative remedies for this situation.

The majority of the allowance for uncollectible accounts came from Medicare contractor data based on the last five years (if available) of historical loss experience by type. The allowance was adjusted for those contractors that did not report historical loss experience. The remainder of the allowance was reported by HCFA components as a result of an analysis of individual debtors and a group analysis that included accounts receivable that were outstanding for more than one year and did not have payment activity within that year.

The accounts receivable does not include established or contingent amounts due to States for overpayment of Medicaid funds to providers or for anticipated rebates from drug manufacturers, settlements from probate and fraud and abuse cases, or payments from insurance companies deemed to be primary payers. HCFA is not responsible for collecting amounts owed to States under the Medicaid program. Therefore, HCFA reimburses States for actual expenses reported net of collections for the situations listed above. HCFA's reporting of the same accounts receivable as the States, when nothing is in fact directly owed HCFA, would overstate HCFA's Medicaid assets and provide misleading information. Data is not available to determine that the cost of developing standard reporting by the States or implementing and maintaining control processes by HCFA would provide increased accountability or increased credits to the Medicaid program.

The Office of Inspector General believes that the accounts receivable balance could be materially understated if the State receivables are not reflected on HCFA's records. Since the issue affects accounting and financial reporting for all Department of Health and Human Services public assistance programs and government-wide grant programs, HCFA has asked the Federal Accounting Standards Advisory Board to address the issue.

Note 4: Investments and Interest Receivable (Dollars in Millions)

	MATURITY RANGE	INTEREST RANGE	VALUE
HI			
Certificates	June 1995	7 1/8 - 7 3/8%	$868
Bonds	June 1995 to June 2009	6 1/4 - 13 3/4%	127,847
TOTAL HI INVESTMENTS			**$128,715**
SMI			
Certificates	June 1995	7 1/8 - 7 3/8%	$91
Bonds	June 1995 to June 2009	6 1/4 - 13 3/4%	21,398
TOTAL SMI INVESTMENTS			**$21,489**
TOTAL MEDICARE TRUST FUND INVESTMENTS			**$150,204**

U.S. Treasury Special Issues are special public obligations for exclusive purchase by the Medicare trust funds. Special issues are always purchased and redeemed at face value. The face value less amounts retired to fund Medicare program expenses by the programs is the net amount outstanding reported in the Combined Statement of Financial Position. This schedule summarizes the nature and amount of investments in the Medicare trust funds. See Statement of Accounts for HI and SMI Trust Fund Investments for a detailed description of the holdings.

Interest Receivable
The interest receivable is reported to HCFA by the U.S. Treasury and reflects the interest due the trust funds as of September 30, 1994, from the investments listed above.

Note 5: Accounts Payable (Dollars in Millions)

INTRAGOVERNMENTAL

Intragovernmental liabilities include:

* $22 due the U.S. Treasury for the uncollected portion of Trust Fund Miscellaneous Receipts;
* $7 accrual of HCFA postal and rental expenses due the U.S. Post Office and General Services Administration, respectively; and
* $3,681 due the General Fund of the U.S. Treasury as a result of the current method used to certify wages by the Department of Health and Human Services (see Note 8).

GOVERNMENTAL

The $27,590 reported as accounts payable (Governmental) includes a $24,985 estimate by HCFA's Office of the Actuary (OACT) of Medicare services for which payment has not yet been drawn from the HI or SMI trust funds as of September 30, 1994. The estimates are based on historical trends of completeness that take into consideration estimated deductible and coinsurance amounts. They include, for both the HI and SMI programs, (1) services that have been incurred and not yet billed to the Medicare contractors, (2) claims that have been submitted to the Medicare contractors but not yet approved for payment, (3) claims that have been approved but payment has not yet been made by the Medicare contractors, and (4) checks issued in payment of a claim that have not been presented for payment and, therefore, funds have not yet been withdrawn from the HI or SMI trust funds. Actuarial techniques are used to develop an estimate for services performed but not yet billed. The payable estimate is a by-product of the actuarial estimates that are included in the HI and SMI Annual Reports of the Boards of Trustees (whose methodology is also employed in all annual budget exercises including the President's Budget and Mid-Session Review and in the annual development of the SMI premium). Moreover, the actuarial estimated accounts payable is a volatile amount due to the health care environment and slight differences in the accumulated incurred benefits and accumulated cash benefits can cause substantial changes in the estimated amount.

Additionally, the accounts payable includes:

* $2,553 estimated amount due to States under the Medicaid program for reported expenses not yet paid;

* $46 accrual of HCFA Demonstrations Projects and HMO Benefit Payments; and

* $6 accrual for Program Management rent, utility and miscellaneous charges.

The accounts payable does not include all provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB). The monetary effect of these appeals is generally not known until a decision is rendered.

As of September 30, 1994, there were 8,351 cases in appeal at the PRRB. Over 3,400 of these cases were filed in FY 1994. The PRRB rendered decisions on 80 cases in FY 1994 while 1,794 additional cases were dismissed, withdrawn or settled prior to an appeal hearing. The Board gets no information on the value of these cases that are settled prior to a hearing. In addition, a reasonable liability estimate cannot be projected for the value of the 8,351 cases remaining in appeal as of September 30 from the data available for the 80 cases that were decided in FY 1994. As cases are decided, the settlement value paid is considered in the development of the actuarial liability estimate.

In addition, HCFA does not report an accounts payable for Medicaid claims/services incurred but not yet processed and paid by the States. HCFA does not receive bills nor service incurred data as they relate to the Medicaid provider or beneficiary and therefore, does not have a legal or financial relationship with either. HCFA provides a grant to the State for reimbursement of the Federal share of actual State expenses. The approved expenditure report is the basis for reimbursement of incurred expenses to the State. In order for HCFA to record the actuarial estimated liabilities of each State for claims/services incurred but not yet processed, each State would be required to develop the estimate using a standard methodology, report the data timely to HCFA in accordance with HCFA's fiscal year, and provide HCFA with access to validate the estimate.

The Office of Inspector General believes that the accounts payable is materially understated if the States' estimates for claims/services incurred but not yet processed and paid are not reflected on HCFA's records. Since the issue affects other Federal agencies administering grant programs, HCFA has asked the Federal Accounting Standards Advisory Board to address the issue.

Note 6: Other Liabilities (Dollars in Millions)

	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Liabilities Covered by Budgetary Resources						
Governmental:						
Premiums Billed/Not Yet Due and Unearned Advances	$80	$219	$299			**$299**
Liabilities not Covered by Budgetary Resources						
Intragovernmental:						
Uncollected Revenue due Treasury					$159	**$159**
Governmental:						
Medicaid Audit Disallowances Under Appeal				$6		$6
Medicaid Program Disallowances Under Appeal				17		17
Medicaid Program Deferrals				156		156
Total Other Governmental Liabilities not Covered By Budgetary Resources				$179		**$179**

Liabilities covered by budgetary resources ($299) consist of (1) Medicare premiums billed (included in the FY 1994 accounts receivable reported) prior to September 30, 1994, but due in the following reporting period and (2) premiums that were received but unbilled.

Liabilities not covered by budgetary resources ($159) include uncollected revenue due Treasury. As a result of a change in accounting policy discussed in Note 1, the uncollected portion of General Fund Miscellaneous Receipts, e.g. interest, fees, penalties, that have previously been recorded in Equity are now reported as a liability to the U.S. Treasury.

In addition, liabilities not covered by budgetary resources ($179) include contingent payables that have been established as a result of Medicaid audit and program disallowances that are currently being appealed by States. In all cases, the funds have been returned to HCFA. Accordingly, HCFA will be required to pay these amounts if the appeals are decided in favor of the States. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a State. HCFA defers the payment of these claims until the State provides additional supporting data. Based on historical data, HCFA expects to eventually pay 36.6% of total contingent payables. Therefore, of the total contingent payables of $489, HCFA expects to pay approximately $179.

Note 7: Net Position (Dollars in Millions)

BY PROGRAM	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total	
Unexpended Appropriations:							
Unobligated							
Available	$108,687	$17,774	$126,461	$13,033	$17	$139,511	
Unavailable					10,737	10,737	
Undelivered Orders	565	314	879	1,943	8	2,830	
Invested Capital	11	14	25	1		26	
Less: Future Funding Requirements	7	18	25	179		204	(1)
Total	**$109,256**	**$18,084**	**$127,340**	**$14,798**	**$10,762**	**$152,900**	

BY FUND TYPE	Revolving Funds	Trust Funds	Approriated Funds	Combined Total	
Unexpended Appropriations:					
Unobligated					
Available	$17	$126,461	$13,033	$139,511	
Unavailable			10,737	10,737	
Undelivered Orders	8	879	1,943	2,830	
Invested Capital		25	1	26	
Less: Future Funding Requirements		25	179	204	(1)
Total	**$25**	**$127,340**	**$25,535**	**$152,900**	

(1)Future funding will be required to pay the current year accrual for annual leave that has been allocated to the Medicare trust funds and Medicaid, for the current year liabilities (audit/ program disallowances and deferrals) of the Medicaid program, and for current year Federal Employees' Compensation Benefit expenses.

Note 8: Employment Tax Revenue (Dollars in Millions)

In calendar year 1994, all employees and employers were required to contribute 1.45 percent of employees' wages, with no limitation, to the Federal Medicare Hospital Insurance (HI) Trust Fund.

The Social Security Act requires the transfer of these contributions from the General Fund of the U.S. Treasury to the HI Trust Fund based on certified wages (reported via Form W-3) established and maintained by the Secretary of Health and Human Services. However, since tax year 1978, the Social Security Administration (SSA) has used the generally higher wage totals reported by employers via the quarterly Internal Revenue Service's (IRS) Form 941 (in lieu of Form W-3) as the basis for conducting an interim certification of regular wages. SSA has proposed a legislative amendment which would authorize the retroactive use of U.S. Treasury wage data (Form 941), thereby facilitating final certification. Until the situation is resolved, HCFA has recognized an Employment Tax Liability on the FY 1994 Statement of Financial Position of $3,336 and $345 for FYs 1993 and prior and FY 1994, respectively. If a transfer of funds occurs, there may also be a related interest transfer of approximately $2,150. SSA states the probability that an actual transfer will occur cannot be predicted but they believe it is remote.

Employment tax revenues are adjusted by excess contributions collected that are refunded to employees. FY 1994 HI Trust Fund employment tax revenue and refunds as reported by the U.S. Treasury are listed below. In addition, HCFA has recorded an adjustment to the Employment Tax Revenue for the FY 1994 portion of the Employment Tax Liability. (See Notes 5 and 14)

Employment Tax Revenue	$92,100
Less Refunds	73
Less Current Year Offset for Employment Tax Liability	345
Employment Tax Revenue, Net	$91,682

Note 9: SMI Premiums Collected and Federal Matching Contributions

SMI benefits and administrative expenses are financed by monthly premiums paid by Medicare beneficiaries and matched by the Federal government. The Omnibus Budget Reconciliation Act of 1990 set specific monthly premium levels for five calendar years beginning in 1991. The monthly premium in calendar year 1994 was $41.10 and covered 28.1 percent of the SMI program's estimated 1994 costs. Premiums collected from beneficiaries totalled $16.9 billion in FY 1994 and were matched by a $38.4 billion contribution from the Federal government. This represents a Federal match of approximately $2.27 to every $1 collected in premiums.

Note 10: Other Revenue and Financing Sources (Dollars in Millions)

	Medicare HI	Medicare SMI	Total Medicare	All Others	Combined Total
Premiums-Uninsured Individuals	$852		$852		$852
Transfer-Uninsured Coverage	607		607		607
Military Service Contribution	80		80		80
Principal Payments				$7	7
Income Tax Credit Reimbursement	1		1		1
Income Tax OASDI Benefits	1,639		1,639		1,639
Gifts and Miscellaneous	1	$2	3		3
Total Other Revenue	**$3,180**	**$2**	**$3,182**	**$7**	**$3,189**

Note 11: Expenses by Object Class (Dollars in Millions)

	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Program Expenses by Object Class:						
Medicare						
Insurance Claims and Indemnities	$111,027	$59,517	$170,544			$170,544
Medicaid						
Grants, Subsidies and Contributions				$86,670		86,670
Other Expenses *(See Note 13)*				(355)		(355)
Total Program Expenses	**$111,027**	**$59,517**	**$170,544**	**$86,315**		**$256,859**
Operating Expenses by Object Class:						
Administrative						
Personal Services and Benefits	$99	$197	$296	$16	$5	$317
Contractual Services	761	1,523	2,284	123	36	2,443
Total Operating Expenses	**$860**	**$1,720**	**$2,580**	**$139**	**$41**	**$2,760**
Other						
Travel and Transportation	$2	$5	$7			$7
Rental, Communication and Utilities	9	17	26	$1		27
Printing and Reproduction	2	4	6			6
Supplies and Materials		1	1			1
Total Other Expenses	**$13**	**$27**	**$40**	**$1**		**$41**
Depreciation and Amortization	$1	$4	$5			$5
Total Expenses by Object Class	**$111,901**	**$61,268**	**$173,169**	**$86,455**	**$41**	**$259,665**

Note 12: Administrative Expenses (Dollars in Millions)	
MEDICARE	
Hospital Insurance	
U.S. Department of Treasury	$32
Social Security Administration (SSA)	432
Health Care Financing Administration	592
Office of the Secretary - DHHS	18
Payment Assessment Commission	4
Policy and Research	4
Railroad Retirement Board	(394)
Peer Review Organizations	185
TOTAL HI ADMINISTRATIVE EXPENSE	**$873**
Supplementary Medical Insurance	
U.S. Dept. of Treasury/Office of Personnel Mgmt.	$1
Social Security Administration	324
Health Care Financing Administration	1,385
Office of the Secretary - DHHS	14
Payment Assessment Comm./SSA Construction	1
Policy and Research	2
Physicians Payment Review Commission	4
Railroad Retirement Board	6
Peer Review Organizations	10
TOTAL SMI ADMINISTRATIVE EXPENSE	**$1,747**
TOTAL MEDICARE TRUST FUND ADMINISTRATIVE EXPENSE	**$2,620**
MEDICAID	
Health Care Financing Administration	$140
TOTAL ADMINISTRATIVE EXPENSES	**$2,760**

For purposes of financial statement presentation, administrative costs are considered expensed to the Medicare trust funds when outlayed by the U.S. Treasury even though some funds may have been used to pay for assets such as property and equipment. In this regard, the Social Security Administration (SSA) reported $82.5 million of Property and Equipment, Net, attributable to the Medicare program as of September 30, 1994. This amount is not included in HCFA's Combined Statement of Financial Position as assets related to the Medicare program. However, funds withdrawn from the trust funds by SSA during FY 1994 to pay for this activity are included in this section as an administrative expense to the Medicare program. The SSA administrative costs are reported to HCFA by the U.S. Treasury. These expenses are also reported by SSA on their FY 1994 Annual Financial Statement.

HCFA's administrative costs have been allocated to the Medicare and Medicaid programs based on the HCFA cost allocation system. Administrative costs allocated to the Medicare program include $1.5 billion paid to Medicare contractors to carry out their responsibilities as HCFA's agents in the administration of the Medicare program.

Note 13: Other Expenses (Dollars in Millions)	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Fiscal Year 1994 Contingent Liabilities						
Program Deferrals					$(177)	$(177)
Program Disallowances Under Appeal					(176)	(176)
Audit Disallowances Under Appeal					(2)	(2)
Total Other Expenses					**$(355)**	**$(355)**

Medicaid audit and program disallowances under appeal and Medicaid deferrals are classified as liabilities not covered by budgetary resources on the Statement of Financial Position. As discussed in Note 6, Other Governmental Liabilities, these contingent amounts will be paid if the appeals are decided in favor of the claimant and if additional data is provided to support the legitimacy of a Medicaid expenditure claim. Negative expense amounts are shown because more liabilities established in prior fiscal years were settled during FY 1994 than were recognized in the current year.

Note 14: Prior Period Adjustments (Dollars in Millions)	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Equipment Adjustment (1)	$(1)	$(2)	$(3)			$(3)
Unfunded FECA Expense (2)	(2)	(4)	(6)			(6)
Uncollected Revenue moved from Equity to Accounts Payable (3)	(11)	(35)	(46)		$(114)	(160)
Employment Tax Liability for FY 1993 and prior (4)	(3,336)		(3,336)			(3,336)
TOTAL PRIOR PERIOD ADJUSTMENTS	**$(3,350)**	**$(41)**	**$(3,391)**		**$(114)**	**$(3,505)**

(1) HCFA's FY 1993 financial statement reflected equipment maintained by the Department's Regional Administrative Service Center. In FY 1994, in anticipation of HCFA's assuming the Department's accounting duties, HCFA inventoried the equipment in the Department's reports and revised the equipment amount on HCFA's records resulting from that inventory.

(2) Due to the establishment of an expense for Federal Employees' Compensation Benefits (FECA) in FY 1994 by the Department of Labor, a prior-period expense was recorded in HCFA's Program Management appropriation to account for a FECA actuarial liability associated to prior periods.

(3) Prior-period Equity is adjusted to reflect the change in accounting policy discussed in Note 1 that requires the treatment of the uncollected portion of Miscellaneous Receipts due Treasury as an accounts payable in FY 1994 rather than as Equity.

(4) Prior-period Equity is adjusted to recognize the portion of the Employment Tax Liability attributable to FY 1993 and prior. (See Note 8.)

Note 15: Non-Operating Changes (Dollars in Millions)

	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Equipment Transferred In	$1		$1			$1
Cancelled Year Funds	(3)	$(7)	(10)			(10)
Current Year Warrants Exceeding Appropriated Capital Used				$2,407	$6,769	9,176
TOTAL NON-OPERATING CHANGES	**$(2)**	**$(7)**	**$(9)**	**$2,407**	**$6,769**	**$9,167**

Supplemental Information

TOTAL OUTLAYS

(Dollars in Millions)	FY 1992	FY 1993	FY 1994
Medicare Benefits:			
HI	$80,584	$90,535	$102,376
SMI	48,596	52,398	59,721
Total	$129,180	$142,933	$162,097
Medicaid Grants to States			
Medical Assistance Payments	$65,359	$72,791	$78,763
State & Local Administration	2,468	2,983	3,271
Total	$67,827	$75,774	$82,034
Administration			
Program Management	$2,096	$2,044	$2,112
Peer Review Organization	232	214	195
Social Security Administration	662	680	757
Other Non-HCFA Federal	87	108	86
CLIA	4	21	26
Total	$3,081	$3,067	$3,176
Total Program Outlays	$200,088	$221,774	$247,307

TOTAL ENROLLEES

(Persons in Millions)	FY 1992	FY 1993	FY 1994
Medicare	35.4	36.1	37.0
Medicaid	30.9	33.3	34.9
Total	66.3	69.4	71.9

Total includes persons enrolled in both programs.

MEDICARE BENEFIT OUTLAYS

(Dollars in Millions)	FY 1992	FY 1993	FY 1994
HI:			
Inpatient Hospital	$69,145	$75,021	$81,051
Skilled Nursing Facility	3,645	5,027	7,116
Home Health	6,986	9,529	12,005
Hospice	808	958	1,363
Total	$80,584	$90,535	$101,535
SMI:			
Physician	$32,304	$33,800	$37,292
Outpatient	10,671	11,916	13,155
Group Practice	3,810	4,550	5,464
Independent Lab	1,735	2,031	1,958
Other	75	101	137
Total	$48,595	$52,398	$58,006
Total Benefit Outlays	$129,179	$142,933	$159,541

MEDICARE ENROLLEES

(Persons in Millions)	FY 1992	FY 1993	FY 1994
HI:			
Aged	30.8	31.6	32.2
Disabled	3.6	3.8	4.2
Total	34.4	35.4	36.4
SMI:			
Aged	30.5	31.0	31.4
Disabled	3.2	3.4	3.6
Total	33.7	34.4	35.0

HOSPITAL INSURANCE TRUST FUND PROJECTIONS

(Dollars in Billions)

Calendar Year	Total Income	Total Disbursements	Net Increase in Fund	Fund at End of Year	Ratio: Assets to Disbursements
1993	98.2	94.4	3.8	127.8	131.0
1994	107.5	107.2	0.3	128.1	119.0
1995	119.0	116.6	2.4	130.5	110.0
1996	124.1	127.7	(3.6)	126.9	102.0
1997	129.4	138.8	(9.4)	117.5	91.0
1998	134.7	151.3	(16.6)	100.9	78.0
1999	139.9	165.2	(25.3)	75.6	61.0
2000	145.3	180.5	(35.2)	40.4	42.0
2001	150.7	197.2	(46.4)	1/	20.0

1/ Trust Fund Depleted in year 2001

Reflects intermediate actuarial assumptions of the 1994 Annual Report of the Trustees of the HI Trust Fund.

SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND PROJECTIONS

(Dollars in Billions)

Calendar Year	Enrollee Premiums	Other Income	Total Income	Total Disbursements	Fund at End of Year
1993	14.2	43.5	57.7	56.0	24.1
1994	17.4	37.6	55.0	61.8	17.4
1995	19.8	41.7	61.6	69.4	9.5
1996	19.2	59.2	78.3	77.6	10.3
1997	21.4	65.8	87.2	86.4	11.1
1998	23.9	73.8	97.2	96.3	11.9
1999	25.1	83.6	108.6	107.6	12.9
2000	26.2	95.2	121.4	120.4	14.0
2001	27.5	108.6	136.1	134.9	15.2
2002	28.9	124.0	152.8	151.5	16.6
2003	30.4	141.6	171.9	170.4	18.1

Reflects intermediate actuarial assumptions of the 1994 Annual Report of the Trustees of the SMI Trust Fund.

MEDICARE PEER REVIEW ORGANIZATION COSTS

	FY 1992	FY 1993	FY 1994
(Dollars in Millions)			
Obligations	$188	$475	$171
Outlays	$232	$214	$195

MEDICAID MEDICAL ASSISTANCE BY SERVICE

	FY 1992	FY 1993	FY 1994
(Dollars in Billions)			
Inpatient Hospital	$37.5	$39.6	$39.5
Mental Health Facility	4.9	5.0	5.8
Nursing Facility	24.4	26.1	28.1
ICF/MR	8.7	9.3	9.2
Prescription Drugs	6.2	6.9	7.5
Physician	6.7	7.4	7.6
Health Insurance	5.7	7.8	10.5
Outpatient Hospital	5.5	6.3	6.5
Home Health/Personal Care/ HCBW/Community	5.8	6.8	8.5
Clinic	2.3	2.7	2.9
Other	8.2	8.0	11.5
Total Expenditures	$115.9	$125.9	$137.6
Total Outlays	$118.2	$131.8	$143.2

MEDICAID OUTLAYS

	FY 1992	FY 1993	FY 1994
(Dollars in Millions)			
Federal Outlays:			
Medical Assistance	$65,359	$72,791	$78,763
Administration	2,468	2,983	3,271
Total Federal	$67,827	$75,774	$82,034
State Outlays:			
Medical Assistance	$48,466	$53,802	$58,638
Administration	1,873	2,199	2,532
Total State	$50,339	$56,001	$61,170
Total Outlays	$118,166	$131,775	$143,204

MEDICAID ENROLLEES

	FY 1992	FY 1993	FY 1994
(Persons in Millions)			
Needy Adults	7.0	7.5	7.7
Needy Children	15.1	16.3	16.9
Disabled	4.5	5.0	5.6
Elderly	3.7	3.9	4.0
Other	0.7	0.6	0.7
Total	31.0	33.3	34.9

HCFA PROGRAM MANAGEMENT OUTLAYS

	FY 1992	FY 1993	FY 1994
(Dollars in Millions)			
Research	$59	$69	$72
Medicare Contractors	1,502	1,503	1,545
State Certification	134	136	165
Administrative Costs	323	335	330
Adjustments	78	1	.....
Total Outlays	$2,096	$2,044	$2,112

MEDICARE PAYMENT SAFEGUARDS

	FY 1992	FY 1993	FY 1994
(Dollars in Millions)			
Investments (Outlays)	$351	$406	$412
Savings:			
Medicare Secondary Payer	$2,810	$3,135	$2,963
Provider Audit	974	1,711	1,117
Medical & Utilization Review	1,382	1,412	1,231
Total Savings	$5,166	$6,258	$5,311

MEDICARE CLAIMS PROCESSING MEASURES

	FY 1992	FY 1993	FY 1994
Claims Submitted Electronically:			
Part A	81%	88%	93%
Part B	50%	61%	71%
Claims Processing Backlog (as Percent of Total Claims):			
Part A	1.5%	1.5%	1.2%
Part B	2.0%	1.8%	1.7%
Processing Unit Costs:			
Part A	$2.78	$2.61	$2.45
Part B	$1.71	$1.60	$1.52

MEDICARE STATE CERTIFICATION, FY 1994

	Facilities	Surveys	Coverage
SNF (Medicare Only)	1,126	1,054	94%
SNF (Medicare/Medicaid)	11,494	10,677	93%
Hospital (Non-Accredited)	1,389	524	38%
Hospital (Accredited)	5,028	1,669	33%
Home Health Agency	8,102	7,007	86%
ESRD Facility	2,657	1,023	39%
Hospice	1,682	635	38%
Mammography	7,165	3,351	47%
Other	6,773	3,026	45%
Total	45,416	28,966	64%

MEDICARE STATE CERTIFICATION MEASURES

	FY 1992	FY 1993	FY 1994
Facilities Cited for Deficiencies:			
Condition-Level Deficiencies	1,638	1,876	1,910
Standard-Level Deficiencies	18,087	18,399	19,187
As Percent of Facilities Surveyed:			
Condition-Level Deficiencies	6%	7%	7%
Standard-Level Deficiencies	65%	65%	67%

Research and Demonstrations

The goal of HCFA's research, demonstration, and evaluation program is to provide timely, reliable information required for informed and rational decision-making in the Medicare and Medicaid programs.

This goal was pursued through seven primary objectives:

1. To improve access and quality of care for Medicare and Medicaid beneficiaries.

2. To increase health service delivery options for consumers.

3. To further refine existing payment systems for hospital, physician, and outpatient care.

4. To increase understanding of the problems of health care access and financing in the United States.

5. To increase understanding of how the health care market has responded to changes in the Medicare and Medicaid programs.

6. To assess how quality health services should be efficiently and effectively delivered.

7. To better understand trends and factors affecting cost, accessibility, and quality of subacute and long-term care under Medicare and Medicaid.

HCFA made significant strides toward fulfilling its primary research objectives. Major accomplishments included:

- Operation of several programs to support rural health care access, including the Rural Health Care Transition Grant Program, the Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) Grant Program, and the State Rural Health Network Reform Initiative.

- Five additional telemedicine sites were awarded to evaluate the effectiveness of rural telemedicine systems and to test payment methodologies for physician services rendered via telemedicine.

- Medicaid reform demonstrations were approved in Florida and South Carolina. HCFA continues to monitor the demonstrations which have been implemented in Oregon, Hawaii, Rhode Island, and Tennessee. In addition, HCFA awarded contracts to evaluate these statewide demonstrations.

- Development of an outpatient classification system continued.

- Research was initiatied and conducted to support further refinements of the Medicare Physician Fee Schedule for physician services.

- A series of research projects was conducted to develop and refine Medicare and Medicaid payment systems.

- Further research was conducted to assess the impact of the Medicare Fee Schedule for physician services on beneficiary access.

- Research was conducted in support of the Consumer Information Strategy, including work on influenza immunization, mammography examination, and options for treating breast cancer.

- Research projects were expanded to develop additional information regarding risk-adjustment for capitated payments.

- Research was initiated to examine what types of information consumers would find useful in selecting health insurance plans and providers.

- Development and refinement of an alternative nursing home resident assessment and care planning tool continued. This tool provides core information to be used in testing prospective case-mix adjustment payment, as well as an outcome oriented quality assurance system for nursing home patients.

- Demonstrations were initiated to test an outcome-based quality assurance system for health agencies and nursing homes. This research formed the basis for activities related to revising the quality assurance model for HHAs and SNFs.

- Initiated a managed care demonstration to integrate acute and long-term care services.

The HCFA Office of Research and Demonstrations funded 192 extramural research projects, including 103 new projects and 89 continued from previous years. HCFA also issued 540 grants under four major grant programs. Obligations totaled $80 million, of which $42.8 million was devoted to the ongoing research program and $37.2 million to Congressional grant programs. A total of $18.3 million was spent on Medicaid research, $24.5 million on Medicare research.

Grant activity included the Rural Health Care Transition program, totaling $21 million in grants to 445 hospitals; State Rural Health Network Reform Initiative, totaling $1.6 million to six States; Essential Access Community Hospital/Rural Primary Care Hospital Grant Program (EACH/RPCH), totaling $4.6 million to seven States and 29 hospitals; and Insurance Counseling grants, totaling $9.9 million awarded to the 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands.

Federal Managers' Financial Integrity Act

High Risk Area

Medicare Secondary Payer (MSP). Over the last several years, HCFA has actively pursued several initiatives to improve the MSP program: legislative proposals, litigation against noncomplying insurers, and data matches with SSA and the IRS. Nonetheless, some estimates project that the Medicare program may unnecessarily pay out as much as $400 million annually because fiscal intermediaries and carriers do not always identify primary payers when they should. However, due to improvements in the MSP program, savings computations for FY 1993 tally $3.1 billion and it is now estimated that savings will reach at least $3.3 billion for FY 1994. The return on investment is impressive — for every dollar spent in FY 1994 on administrative costs (including recovery), $28 was saved.

Ongoing initiatives will focus on (1) preventing inappropriate primary payments by Medicare through implementation of the initial enrollment questionnaire (IEQ) for beneficiaries, (2) continued litigation clarifying the extent as to Medicare fiscal agent responsibilities, and (3) developing an improved reporting mechanism for accounts receivable.

Material Weaknesses

Indirect Medical Education (IME). Some Medicare hospitals were overpaid for IME because HCFA did not have a record of the interns and residents that worked at Veteran's Administration (VA) and the Department of Defense (DOD) hospitals in its computer matching data base, and some duplications were not detected. HCFA is coordinating data exchanges with VA and DOD to resolve this problem.

Medicare Contractor Accounts Receivable. Numerous discussions have been held between HCFA and OIG staff regarding the ability of contractor controls to comprehensively monitor accounts receivable data. HCFA responded proactively by awarding funds for a pilot project to develop a protocol for use by contractors to self-assess key internal controls. The protocol will focus on a wide range of contractor activities including systems' ability to properly record and monitor financial mangement data. The CPA firm which audits the non-Medicare side of Blue Cross of Georgia is developing and testing the pilot protocol. During FY 1995, HCFA plans to review the results and to consider the applicability of a self-assessing protocol for all Medicare contractors. A workgroup consisting of contractors, OIG, and HCFA personnel will collaborate on the protocol.

Funding Payment Safeguards. Inadequate and/or fluctuating program funding for payment safeguards has prevented Medicare contractors from maintaining adequate, well-trained, and experienced staff to perform the payment safeguard functions in accordance with program guidelines. To avoid these uncertainties and fluctuations in contractor safeguards, HCFA is planning an innovative Benefits Quality Assurance Program, which would be funded directly from the Medicare Trust Fund.

STATEMENT OF ACCOUNT FOR HI TRUST FUND INVESTMENTS
DESCRIPTION OF HOLDINGS AS OF SEPTEMBER 30, 1994

U.S. TREASURY SPECIAL ISSUES:

Certificates of Indebtedness:	Amount Issued	Less Amount Retired	Net Amount Outstanding
7-3/8% maturing June 30, 1995	$7,564,656,000.00	$7,564,656,000.00	$0.00
7-1/8% maturing June 30, 1995	8,149,929,000.00	8,149,929,000.00	0.00
7-1/4% maturing June 30, 1995	8,526,370,000.00	7,658,174,000.00	868,196,000.00
Total Certificates of Indebtedness	$24,240,955,000.00	$23,372,759,000.00	$868,196,000.00

Bonds:

	Amount Issued	Less Amount Retired	Net Amount Outstanding
13-3/4% due June 30, 1999	$850,544,000.00	$0.00	$850,544,000.00
13-3/4% due June 30, 1998	262,134,000.00	0.00	262,134,000.00
13-1/4% due June 30, 1997	1,450,129,000.00	0.00	1,450,129,000.00
13-1/4% due June 30, 1996	272,853,000.00	0.00	272,853,000.00
13-1/4% due June 30, 1995	272,853,000.00	0.00	272,853,000.00
13% due June 30, 1996	1,177,276,000.00	0.00	1,177,276,000.00
13% due June 30, 1995	197,606,000.00	0.00	197,606,000.00
10-3/4% due June 30, 1998	588,410,000.00	0.00	588,410,000.0
10-3/8% due June 30, 2000	1,277,566,000.00	0.00	1,277,566,000.00
10-3/8% due June 30, 1999	427,022,000.00	0.00	427,022,000.00
10-3/8% due June 30, 1998	427,022,000.00	0.00	427,022,000.00
9-3/4% due June 30, 1995	979,670,000.00	0.00	979,670,000.00
9-1/4% due June 30, 2003	4,229,944,000.00	0.00	4,229,944,000.00
9-1/4% due June 30, 2002	1,034,542,000.00	0.00	1,034,542,000.00
9-1/4% due June 30, 2001	1,034,542,000.00	0.00	1,034,542,000.00
9-1/4% due June 30, 2000	1,034,542,000.00	0.00	1,034,542,000.00
9-1/4% due June 30, 1999	1,034,542,000.00	0.00	1,034,542,000.00
9-1/4% due June 30, 1998	1,034,541,000.00	0.00	1,034,541,000.00
9-1/4% due June 30, 1997	1,034,541,000.00	0.00	1,034,541,000.00
9-1/4% due June 30, 1996	1,034,541,000.00	0.00	1,034,541,000.00
9-1/4% due June 30, 1995	1,034,541,000.00	0.00	1,034,541,000.00
8-3/4% due June 30, 2005	6,415,695,000.00	0.00	6,415,695,000.00
8-3/4% due June 30, 2004	6,415,695,000.00	0.00	6,415,695,000.00
8-3/4% due June 30, 2003	2,185,751,000.00	0.00	2,185,751,000.00
8-3/4% due June 30, 2002	2,185,751,000.00	0.00	2,185,751,000.00
8-3/4% due June 30, 2001	2,185,751,000.00	0.00	2,185,751,000.00
8-3/4% due June 30, 2000	2,185,751,000.00	0.00	2,185,751,000.00
8-3/4% due June 30, 1999	2,185,751,000.00	0.00	2,185,751,000.00
8-3/4% due June 30, 1998	2,185,752,000.00	0.00	2,185,752,000.00
8-3/4% due June 30, 1997	2,185,752,000.00	0.00	2,185,752,000.00
8-3/4% due June 30, 1996	2,185,752,000.00	0.00	2,185,752,000.00
8-3/4% due June 30, 1995	2,185,752,000.00	0.00	2,185,752,000.00
8-5/8% due June 30, 2002	3,195,402,000.00	0.00	3,195,402,000.00
8-5/8% due June 30, 2001	686,250,000.00	0.00	$686,250,000.00
8-5/8% due June 30, 2000	686,250,000.00	0.00	686,250,000.00
8-5/8% due June 30, 1999	686,250,000.00	0.00	686,250,000.00
8-5/8% due June 30, 1998	686,251,000.00	0.00	686,251,000.00
8-5/8% due June 30, 1997	686,251,000.00	0.00	686,251,000.00

Bonds:

	Amount Issued	Less Amount Retired	Net Amount Outstanding
8-5/8% due June 30, 1996	686,250,000.00	0.00	686,250,000.00
8-5/8% due June 30, 1995	686,250,000.00	334,926,000.00	351,324,000.00
8-3/8% due June 30, 2001	2,509,152,000.00	0.00	2,509,152,000.00
8-3/8% due June 30, 2000	1,231,586,000.00	0.00	1,231,586,000.00
8-3/8% due June 30, 1999	1,231,586,000.00	0.00	1,231,586,000.00
8-3/8% due June 30, 1998	1,231,586,000.00	0.00	1,231,586,000.00
8-3/8% due June 30, 1997	1,059,023,000.00	0.00	1,059,023,000.00
8-3/8% due June 30, 1996	1,059,024,000.00	0.00	1,059,024,000.00
8-3/8% due June 30, 1995	1,059,024,000.00	1,059,024,000.00	0.00
8-1/8% due June 30, 2006	7,316,968,000.00	0.00	7,316,968,000.00
8-1/8% due June 30, 2005	901,273,000.00	0.00	901,273,000.00
8-1/8% due June 30, 2004	901,273,000.00	0.00	901,273,000.00
8-1/8% due June 30, 2003	901,273,000.00	0.00	901,273,000.00
8-1/8% due June 30, 2002	901,274,000.00	0.00	901,274,000.00
8-1/8% due June 30, 2001	901,274,000.00	0.00	901,274,000.00
8-1/8% due June 30, 2000	901,274,000.00	0.00	901,274,000.00
8-1/8% due June 30, 1999	901,274,000.00	0.00	901,274,000.00
8-1/8% due June 30, 1998	901,273,000.00	0.00	901,273,000.00
8-1/8% due June 30, 1997	901,273,000.00	0.00	901,273,000.00
8-1/8% due June 30, 1996	901,273,000.00	0.00	901,273,000.00
8-1/8% due June 30, 1995	901,273,000.00	901,273,000.00	0.00
7-3/8% due June 30, 2007	8,184,929,000.00	0.00	8,184,929,000.00
7-3/8% due June 30, 2006	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 2005	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 2004	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 2003	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 2002	867,960,000.00	0.00	867,960,000.00
7-3/8% due June 30, 2001	867,960,000.00	0.00	867,960,000.00
7-3/8% due June 30, 2000	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 1999	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 1998	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 1997	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 1996	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 1995	867,961,000.00	867,961,000.00	0.00
7-1/4% due June 30, 2009	8,773,256,000.00	0.00	8,773,256,000.00
7-1/4% due June 30, 2008	225,130,000.00	0.00	225,130,000.00
7-1/4% due June 30, 2007	225,130,000.00	0.00	225,130,000.00
7-1/4% due June 30, 2006	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 2005	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 2004	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 2003	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 2001	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 2000	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 1999	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 1998	225,130,000.00	0.00	225,130,000.00
7-1/4% due June 30, 1997	225,130,000.00	0.00	225,130,000.00

Bonds:

	Amount Issued	Less Amount Retired	Net Amount Outstanding
7-1/4% due June 30, 1996	225,130,000.00	0.00	225,130,000.00
7-1/4% due June 30, 1995	225,130,000.00	225,130,000.00	0.00
6-1/4% due June 30, 2008	8,548,126,000.00	0.00	8,548,126,000.00
6-1/4% due June 30, 2007	363,197,000.00	0.00	363,197,000.00
6-1/4% due June 30, 2006	363,198,000.00	0.00	363,198,000.00
6-1/4% due June 30, 2005	363,198,000.00	0.00	363,198,000.00
6-1/4% due June 30, 2004	363,198,000.00	0.00	363,198,000.00
6-1/4% due June 30, 2003	363,198,000.00	0.00	363,198,000.00
6-1/4% due June 30, 2002	363,198,000.00	0.00	363,198,000.00
6-1/4% due June 30, 2001	363,198,000.00	0.00	363,198,000.00
6-1/4% due June 30, 2000	363,197,000.00	0.00	363,197,000.00
6-1/4% due June 30, 1999	363,197,000.00	0.00	363,197,000.00
6-1/4% due June 30, 1998	363,197,000.00	0.00	363,197,000.00
6-1/4% due June 30, 1997	363,197,000.00	0.00	363,197,000.00
6-1/4% due June 30, 1996	363,197,000.00	0.00	363,197,000.00
6-1/4% due June 30, 1995	363,197,000.00	363,197,000.00	0.00
Total Bonds	**$131,598,844,000.00**	**$3,751,511,000.00**	**$127,847,333,000.00**
Total U. S. Treasury Special Issues	**$155,839,799,000.00**	**$27,124,270,000.00**	**$128,715,529,000.00**

SOURCE:
DEPARTMENT OF THE TREASURY
FINANCIAL MANAGEMENT SERVICE
FUNDS MANAGEMENT DIVISION
FUNDS ACCOUNTING BRANCH

STATEMENT OF ACCOUNT FOR SMI TRUST FUND INVESTMENTS
DESCRIPTION OF HOLDINGS AS OF SEPTEMBER 30, 1994

U.S. TREASURY SPECIAL ISSUES:

Certificates of Indebtedness:	Amount Issued	Less Amount Retired	Net Amount Outstanding
7-1/4% maturing June 30, 1995	$4,481,175,000.00	$4,390,697,000.00	$90,478,000.00
7-3/8% maturing June 30, 1995	4,524,899,000.00	4,524,899,000.00	0.00
7-1/8% maturing June 30, 1995	4,799,386,000.00	4,799,386,000.00	0.00
Total Certificates of Indebtedness	$13,805,460,000.00	$13,714,982,000.00	$90,478,000.00

Bonds:

	Amount Issued	Less Amount Retired	Net Amount Outstanding
13-3/4% due June 30, 1999	$567,103,000.00	$0.00	$567,103,000.00
13-3/4% due June 30, 1998	110,114,000.00	0.00	110,114,000.00
13-3/4% due June 30, 1997	110,115,000.00	0.00	110,115,000.00
13-3/4% due June 30, 1996	110,115,000.00	0.00	110,115,000.00
13-3/4% due June 30, 1995	110,115,000.00	110,115,000.00	0.00
13-1/4% due June 30, 1997	368,928,000.00	0.00	368,928,000.00
13-1/4% due June 30, 1996	368,928,000.00	0.00	368,928,000.00

Bonds:

	Amount Issued	Less Amount Retired	Net Amount Outstanding
13-1/4% due June 30, 1995	253,926,000.00	253,926,000.00	0.00
10-3/4% due June 30, 1998	456,989,000.00	0.00	456,989,000.00
10-3/4% due June 30, 1997	88,061,000.00	0.00	88,061,000.00
10-3/4% due June 30, 1996	88,061,000.00	0.00	88,061,000.00
10-3/4% due June 30, 1995	88,060,000.00	88,060,000.00	0.00
10-3/8% due June 30, 2000	733,187,000.00	0.00	733,187,000.00
10-3/8% due June 30, 1999	166,084,000.00	0.00	166,084,000.00
10-3/8% due June 30, 1998	166,084,000.00	0.00	166,084,000.00
10-3/8% due June 30, 1997	166,083,000.00	0.00	166,083,000.00
10-3/8% due June 30, 1996	166,083,000.00	0.00	166,083,000.00
10-3/8% due June 30, 1995	166,083,000.00	166,083,000.00	0.00
9-3/4% due June 30, 1995	115,003,000.00	115,003,000.00	0.00
8-3/4% due June 30, 2005	991,433,000.00	0.00	991,433,000.00
8-3/4% due June 30, 2004	991,433,000.00	0.00	991,433,000.00
8-3/4% due June 30, 2003	991,433,000.00	0.00	991,433,000.00
8-3/4% due June 30, 2002	991,433,000.00	0.00	991,433,000.00
8-3/4% due June 30, 2001	547,163,000.00	0.00	547,163,000.00
8-3/4% due June 30, 2000	258,246,000.00	0.00	258,246,000.00
8-3/4% due June 30, 1999	258,246,000.00	0.00	258,246,000.00
8-3/4% due June 30, 1998	258,247,000.00	0.00	258,247,000.00
8-3/4% due June 30, 1997	258,247,000.00	0.00	258,247,000.00
8-3/4% due June 30, 1996	258,247,000.00	9,417,000.00	248,830,000.00
8-3/4% due June 30, 1995	258,247,000.00	258,247,000.00	0.00
8-3/8% due June 30, 2001	444,270,000.00	0.00	444,270,000.00
8-1/8% due June 30, 2006	1,218,813,000.00	0.00	1,218,813,000.00
8-1/8% due June 30, 2005	227,380,000.00	0.00	227,380,000.00
8-1/8% due June 30, 2004	227,381,000.00	0.00	227,381,000.00
8-1/8% due June 30, 2003	227,381,000.00	0.00	227,381,000.00
8-1/8% due June 30, 2002	227,381,000.00	0.00	227,381,000.00
8-1/8% due June 30, 2001	227,381,000.00	0.00	227,381,000.00
8-1/8% due June 30, 2000	227,381,000.00	0.00	227,381,000.00
8-1/8% due June 30, 1999	227,381,000.00	0.00	227,381,000.00
8-1/8% due June 30, 1998	227,380,000.00	0.00	227,380,000.00
8-1/8% due June 30, 1997	227,380,000.00	0.00	227,380,000.00
8-1/8% due June 30, 1996	227,380,000.00	227,380,000.00	0.00
8-1/8% due June 30, 1995	227,380,000.00	227,380,000.00	0.00
7-3/8% due June 30, 2007	1,293,107,000.00	0.00	1,293,107,000.00
7-3/8% due June 30, 2006	74,295,000.00	0.00	74,295,000.00
7-3/8% due June 30, 2005	74,295,000.00	0.00	74,295,000.00
7-3/8% due June 30, 2004	74,294,000.00	0.00	74,294,000.00
7-3/8% due June 30, 2003	74,294,000.00	0.00	74,294,000.00
7-3/8% due June 30, 2002	74,294,000.00	0.00	74,294,000.00
7-3/8% due June 30, 2001	74,294,000.00	0.00	74,294,000.00
7-3/8% due June 30, 2000	74,294,000.00	0.00	74,294,000.00
7-3/8% due June 30, 1999	74,294,000.00	0.00	74,294,000.00
7-3/8% due June 30, 1998	74,294,000.00	0.00	74,294,000.00
7-3/8% due June 30, 1997	74,294,000.00	0.00	74,294,000.00
7-3/8% due June 30, 1996	74,294,000.00	74,294,000.00	0.00

STATEMENT OF ACCOUNT FOR SMI TRUST FUND INVESTMENTS

Bonds:

	Amount Issued	Less Amount Retired	Net Amount Outstanding
7-3/8% due June 30, 1995	74,294,000.00	74,294,000.00	0.00
7-1/4% due June 30, 2009	1,570,476,000.00	0.00	1,570,476,000.00
7-1/4% due June 30, 2008	47,113,000.00	0.00	47,113,000.00
7-1/4% due June 30, 2007	47,112,000.00	0.00	47,112,000.00
7-1/4% due June 30, 2006	47,112,000.00	0.00	47,112,000.00
7-1/4% due June 30, 2005	47,112,000.00	0.00	47,112,000.00
7-1/4% due June 30, 2004	47,112,000.00	0.00	47,112,000.00
7-1/4% due June 30, 2003	47,112,000.00	0.00	47,112,000.00
7-1/4% due June 30, 2002	47,112,000.00	0.00	47,112,000.00
7-1/4% due June 30, 2001	47,112,000.00	0.00	47,112,000.00
7-1/4% due June 30, 2000	47,112,000.00	0.00	47,112,000.00
7-1/4% due June 30, 1999	47,112,000.00	0.00	47,112,000.00
7-1/4% due June 30, 1998	47,112,000.00	0.00	47,112,000.00
7-1/4% due June 30, 1997	47,113,000.00	0.00	47,113,000.00
7-1/4% due June 30, 1996	47,113,000.00	47,113,000.00	0.00
7-1/4% due June 30, 1995	47,113,000.00	47,113,000.00	0.00
6-1/4% due June 30, 2008	1,523,363,000.00	0.00	1,523,363,000.00
6-1/4% due June 30, 2007	230,257,000.00	0.00	230,257,000.00
6-1/4% due June 30, 2006	230,256,000.00	0.00	230,256,000.00
6-1/4% due June 30, 2005	230,256,000.00	0.00	230,256,000.00
6-1/4% due June 30, 2004	230,256,000.00	0.00	230,256,000.00
6-1/4% due June 30, 2003	230,256,000.00	0.00	230,256,000.00
6-1/4% due June 30, 2002	230,256,000.00	0.00	230,256,000.00
6-1/4% due June 30, 2001	230,256,000.00	0.00	230,256,000.00
6-1/4% due June 30, 2000	230,256,000.00	0.00	230,256,000.00
6-1/4% due June 30, 1999	230,256,000.00	0.00	230,256,000.00
6-1/4% due June 30, 1998	230,256,000.00	0.00	230,256,000.00
6-1/4% due June 30, 1997	230,256,000.00	0.00	230,256,000.00
6-1/4% due June 30, 1996	230,256,000.00	230,256,000.00	0.00
6-1/4% due June 30, 1995	230,256,000.00	230,256,000.00	0.00
Total Bonds	**$23,557,143,000.00**	**$2,158,937,000.00**	**$21,398,206,000.00**
Total U.S. Treasury Special Issues	**$37,362,603,000.00**	**$15,873,919,000.00**	**$21,488,684,000.00**

SOURCE:

DEPARTMENT OF THE TREASURY
FINANCIAL MANAGEMENT SERVICE
FUNDS MANAGEMENT DIVISION
FUNDS ACCOUNTING BRANCH

COMBINED STATEMENT OF FINANCIAL POSITION BY ACTIVITY
AS OF SEPTEMBER 30, 1994

(Dollars in Millions)

	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined
ASSETS						
Entity Assets:						
Intragovernmental Assets:						
Fund Balances	$(80)	$(580)	$(660)	$17,176	$10,773	$27,289
Accounts Receivable, Net	1		1			1
Governmental Assets:						
Accounts Receivable, Net	1,754	726	2,480	42	16	2,538
Advances and Prepayments	8	12	20	312	3	335
Property and Equipment, Net	11	14	25	1		26
Total Entity Assets	**$1,694**	**$172**	**$1,866**	**$17,531**	**$10,792**	**$30,189**
Non-Entity Assets:						
Intragovernmental Assets:						
Fund Balances	$916	$1	$917			$917
Interest Receivable	2,656	451	3,107			3,107
Investments	128,715	21,489	150,204			150,204
Governmental Assets:						
Accounts Receivable, Net	86	235	321		$159	480
Total Non-Entity Assets	**$132,373**	**$22,176**	**$154,549**		**$159**	**$154,708**
TOTAL ASSETS	**$134,067**	**$22,348**	**$156,415**	**$17,531**	**$10,951**	**$184,897**

	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined
	(Dollars in Millions)					
LIABILITIES						
Liabilities Covered by Budgetary Resources:						
Intragovernmental Liabilities:						
Accounts Payable	$7	$21	$28	$1		$29
Employment Tax Liability	3,681		3,681			3,681
Liabilities for Loan Guarantees					$28	28
Governmental Liabilities:						
Accounts Payable	21,034	4,003	25,037	2,553		27,590
Suspense Accounts Deposit Funds					2	2
Accrued Payroll and Benefits	2	4	6			6
Other Governmental Liabilities	80	219	299			299
Total Liabilities Covered by Budgetary Resources	**$24,804**	**$4,247**	**$29,051**	**$2,554**	**$30**	**$31,635**
Liabilities not Covered by Budgetary Resources:						
Intragovernmental Liabilities						
Accounts Payable	$2	$4	$6			$6
Uncollected Revenue due Treasury					$159	159
Governmental Liabilities						
Accrued Leave	5	12	17	$1		18
Other Governmental Liabilities				179		179
Total Liabilities not Covered by Budgetary Resources	**$7**	**$16**	**$23**	**$180**	**$159**	**$362**
TOTAL LIABILITIES	**$24,811**	**$4,263**	**$29,074**	**$2,734**	**$189**	**$31,997**
NET POSITION						
Balances:						
Unexpended Appropriations	$109,252	$18,088	$127,340	$14,976	$10,762	$153,078
Invested Capital	11	14	25	1		26
Less: Future Funding Requirements	7	18	25	179		204
TOTAL NET POSITION	**$109,256**	**$18,084**	**$127,340**	**$14,798**	**$10,762**	**$152,900**
TOTAL LIABILITIES & NET POSITION	**$134,067**	**$22,347**	**$156,414**	**$17,532**	**$10,951**	**$184,897**

COMBINED STATEMENT OF OPERATIONS AND CHANGES IN NET POSITION BY ACTIVITY
FOR THE PERIOD ENDING SEPTEMBER 30, 1994

	(Dollars in Millions)					
	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined
REVENUE AND FINANCING SOURCES						
Direct Appropriations Expended				$86,670		$86,670
Employment Tax Revenue	$91,682		$91,682			91,682
SMI Premiums Collected		$16,895	16,895			16,895
Federal Matching Contributions		38,355	38,355			38,355
Revenue From Sales of Goods/Services						
CLIA User Fees					$31	31
Intragovernmental					4	4
Interest & Penalties (Non-Fed)					3	3
Interest (Fed)	10,614	2,088	12,702			12,702
Other Revenue and Financing Sources	3,180	2	3,182		7	3,189
Trust Fund Draws	590	1,380	1,970	139		2,109
Revenue Transfered to Program Management	(744)	(1,365)	(2,109)			(2,109)
Less: Collections for Principal Repayments Transferred To The Federal Financing Bank					6	6
Total Revenues and Financing Sources	**$105,322**	**$57,355**	**$162,677**	**$86,809**	**$39**	**$249,525**
EXPENSES						
Program or Operating Expenses						
Medicare Benefit Payments	$111,02	$59,517	$170,544			$170,544
Medicaid Benefit Payments				$86,670		86,670
Administrative Expenses	873	1,747	2,620	140		2,760
Other					$41	41
Depreciation and Amortization	1	4	5			5
Other Expenses				(355)		(355)
Total Expenses	**$111,901**	**$61,268**	**$173,169**	**$86,455**	**$41**	**$259,665**
Excess (Shortage) of Revenues/Financing Sources Over Total Expenses	**(6,579)**	**(3,913)**	**(10,492)**	**354**	**(2)**	**(10,140)**
Net Position, Beginning Balance	$119,187	$22,045	$141,232	$12,037	$4,109	$157,378
Plus (Minus) Prior Period Adjustments	(3,350)	(41)	(3,391)		(114)	(3,505)
Net Position, Beginning Balance as Restated	115,837	22,004	137,841	12,037	3,995	153,873
Excess (Shortage) of Revenues/Financing Sources Over Total Expenses	(6,579)	(3,913)	(10,492)	354	(2)	(10,140)
Plus (Minus) Non-Operating Changes	(2)	(7)	(9)	2,407	6,769	9,167
NET POSITION, ENDING BALANCE	**$109,256**	**$18,084**	**$127,340**	**$14,798**	**$10,762**	**$152,900**

INSPECTOR GENERAL'S REPORT ON FINANCIAL STATEMENTS

To Bruce C. Vladeck
Administrator of Health Care Financing Administration

OVERVIEW

In accordance with the Chief Financial Officers (CFO) Act of 1990, this report presents the results of our efforts to audit the Health Care Financing Administration's (HCFA) combined financial statements for Fiscal Year (FY) 1994 and an assessment of its internal controls and compliance with laws and regulations.

These statements represent only the third year of HCFA's implementation of the financial statements reporting requirement of the CFO Act. The HCFA's FY 1993 combined financial statements were the first statements that we attempted to audit. The scope of our FY 1993 work was not sufficient to enable us to express an opinion on HCFA's financial statements because significant matters, similar to the accounts receivable and payable issues discussed in this report, limited our ability to apply required audit procedures. As a result of these matters and the material affect of the accounts, we planned our work to audit only the FY 1994 combined statement of financial position.

We were not able to satisfy ourselves as to the fair presentation of the Medicare accounts receivable balance of $2.8 billion. The internal controls over the processing of Medicare accounts receivable were not adequate and it was not practical to extend our audit procedures to substantiate the account balance. The supporting documentation for HCFA's Medicare accounts payable balance of $24.9 billion was not made available to test its accuracy and completeness. Nor could HCFA provide sufficient data to enable us to substantiate the accounts payable balance using alternative auditing procedures. Lastly, because HCFA recorded the Medicaid program on a modified cash accounting basis, it did not record the Federal share of Medicaid accounts receivable and payable amounts recorded on States' records and/or financial statements, and it was impractical for us to determine the total value of these accounts.

Because of the matters discussed in the above paragraph, the scope of our work was not sufficient to enable us to express, and we do not express an opinion on the combined financial statements.

The HCFA has taken several steps to improve its internal control structure and its ability to report reliable financial information. For example, HCFA developed an automated system to capture the Medicare contractors' financial reports and is conducting CFO Act report training seminars with Medicare contractors. Additionally, HCFA is developing a single, integrated claims processing system that will include a fully integrated accrual accounting system. However, some of these efforts will not be implemented for several years and it will take a significant commitment by HCFA to build on efforts now underway to develop new systems and procedures, and institute effective controls. We discussed a draft of this report with HCFA officials who generally concurred with its findings and recommendations.

REPORT ON FINANCIAL STATEMENTS

In accordance with the CFO Act, HCFA prepared the principal financial statements for the fiscal years ended September 30, 1994 and 1993. These statements are the responsibility of HCFA's management, and include the accounts of all funds it administers: the bospital insurance (HI) trust fund, the supplementary medical insurance trust fund, Medicaid grants, and the administrative costs of these funds.

As discussed in tbe Overview section of this report, we were not able to express an opinion on HCFA's FY 1993 financial statements because significant matters, similar to the accounts receivable and payable issues discussed in this report, limited our ability to apply required audit procedures. As a result of these matters and the material effect of the accounts, we planned our work to audit only the FY 1994 combined statement of financial position.

Limitations on our ability to apply certain audit procedures required by *Government Auditing Stondards*, issued by the Comptroller General of the United States, and Office of Management and Budget (OMB) Bulletin 93-06, *Audit Requirements for Federol Financiol Stotements*, precluded us from expressing an opinion on HCFA's combined financial statements.

Medicore Accounts Receivable. We were not able to apply sufficient audit procedures to satisfy ourselves as to the fair presentation of the reported Medicare accounts receivable balance of $2.8 billion at September 30, 1994. The internal controls over the processing of Medicare accounts receivable are still not adequate to reduce, to a low level, the risk that the accounts receivable balance would be materially misstated and it was impractical for us, due to the lack of essential documentation by the Medicare contractors, to extend our audit procedures sufficiently to otherwise substantiate the account balance.

Medicare Accounts Poyoble. The necessary documentation supporting the Medicare accounts payable balance of $24.9 billion, was not made available for us to test the actuarial determination of the account balance. Nor did HCFA provide sufficient data to enable us to substantiate the accounts payable balance using alternative auditing procedures.

The HCFA has enhanced its financial reporting capabilities in this area by using its National Claims History File (NCHF)[1] to identify claims in which services were provided during the year but paid in a subsequent year. Although the timeliness of this data is a concern, we reviewed the most current NCHF data available for an entire year, which pertained to FY 1993, and found discrepancies of about $1.3 billion between the payable amount of $14.2 billion reported at September 30, 1993 and the related NCHF data. Using 6 months of data available pertaining to FY 1994, we estimated there could be discrepancies of about $11.5 billion between the payable amount of $24.9 billion reported at September 30, 1994 and the related NCHF data.

Medicaid Accounts Receivable. As noted in our FY 1993 CFO report on internal controls and compliance issues,[2] HCFA did not record the Federal portion of Medicaid accounts receivable amounts recorded in the States' records and/or financial statements. Nor are the States required to report these Medicaid accounts receivable balances to HCFA. Although our limited tests of the most current available

[1] *The NCHF records oll institutional ond physicion/supplier claims processed by the Medicare benefit coordination and claims validotion system.*

[2] *Heolth Care Financing Administrotion's (HCFA) Internal Control Structure and Compliance With Laws ond Regulations for Fiscol Yeor Ended September 30, 1993 (A-14-93-03026), dated September 29, 1994.*

data, which was 1993,[3] indicated that the Medicaid accounts receivable balances recorded by States could be about a billion dollars, it was impractical for us to extend our tests to satisfy ourselves as to the total Medicaid accounts receivable balance reported by all States.

Medicaid Accounts Payable. The HCFA did not record the Federal portion of Medicaid accounts payable amounts recorded in the States' records and/or financial statements. Nor are the States required to report these Medicaid accounts payable balances to HCFA. Although our limited tests of the most current available data, wbich was 1993, indicated that the Medicaid accounts payable balances recorded by the States could be billions of dollars, it was impractical for us to extend our tests to satisfy ourselves as to the total Medicaid accounts payable balance reported by all States.

Because of the significance of the matters discussed in the preceding paragrapbs, and because we were not able to apply other auditing procedures to satisfy ourselves as to the fair presentation of the accounts involved, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the combined statement of financial position as of September 30, 1994 and 1993.

Consistency of Other Information. We undertook the review of HCFA's combined statement of financial position for the purpose of forming an opinion on this statement which, as described above, resulted in a disclaimer of opinion. The presentation of the financial report includes an overview of operations and supplemental information, which are the responsibility of HCFA's management. This information has not been subjected to auditing procedures and, accordingly, we express no opinion on it.

REPORT ON INTERNAL CONTROLS AND COMPLIANCE WITH LAWS AND REGULATIONS

The results of our tests of internal controls and compliance issues identified four significant conditions: one involving internal controls and three conditions involving noncompliance with laws and regulations at HCFA and/or its Medicare contractors. We believe that the Medicare accounts receivable issue is a reportable condition[4] that is an internal control material weakness[5] under standards established by the American Institute of Certified Public Accountants (AICPA) and OMB Bulletin 93-06. The HCFA reported this condition as a material weakness under its Federal Managers' Financial Integrity Act (FMFIA) program.[6] The results of our tests of compliance with applicable laws and regulations disclosed that HCFA was in compliance, except as described below.[7] With respect to items not tested, nothing came to our attention to cause us to believe HCFA bad not complied with those provisions.

[3] *Due to the single audit requirements, 1994 dato was not ovailable for all States reviewed.*

[4] *A reportable condition is a matter coming to our attention related to o significant deficiency in the design or operotion of the internal control structure that, in our judgement, could adversely offect the organization's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial statements.*

[5] *A material weakness is a reportable condition in which the design or operation of one or more internal control structure elements does not reduce to a relatively low level the risk that errors or irregularities in amounts that would be material in relation to the financiol statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions.*

[6] *The HCFA reported "Medicare Contractor Accounts Receivable" and "Medicare Secondary Payer (MSP)" as materiol weaknesses. The MSP weakness includes establishing an awareness of accounts receivables.*

[7] *Our tests of compliance did not include testing the internal controls over the related accounts.*

MEDICARE ACCOUNTS RECEIVABLE

Our review of Medicare accounts receivable amounts reported by Medicare contractors showed that the contractors and HCFA have not yet effectively implemented internal control procedures necessary to ensure the production of reliable financial statement amounts. Financial reporting control areas which need improvement included controls to ensure that documentation is retained to support reported balances, appropriate summarization and verification of accounts receivable data, and the reliable valuation of recorded accounts receivable amounts. The following exemplifies some of the significant weaknesses we found with the contractors' reporting of receivable balances:

- Six contractors reviewed either did not have adequate documentation or any documentation to support about $102.6 million.
- Four contractors omitted accounts receivable transactions and adjustments of about $14.4 million in their reports to HCFA.
- Three contractors reported presettlement liability cases of about $19 million, which are not accounts receivable due to the uncertainty that the debts actually exist.
- All 11 contractors reviewed either reported no allowance for uncollectible accounts or allowances that did not fairly portray the collectibility of receivables.

Our review also disclosed that the processing of accounts receivable transactions did not occur within the framework of an integrated financial management system because Medicare contractors do not have accounting systems that record, classify, and summarize information for the preparation of financial statements. In addition, HCFA's oversight of contractor operations did not provide reasonable assurance that financial reporting control procedures were being effectively implemented.

Although we noted improvements at contractor operations, we continued to find significant weaknesses with the contractors' reporting of financial information. Due to the brief period of time since we reported the results of our FY 1993 work, we acknowledge that HCFA has not had sufficient time to implement all of our previous recommendations. We have worked with and will continue to assist HCFA to improve its internal control structure. These weaknesses, including our recommendations, are discussed in greater detail in our draft report, *Report on the Health Care Financing Administration's Internal Control Structure Over Medicare Accounts Receivables for the Fiscal Year Ended September 30, 1994* (A-01-94-00520), dated March 1995.

MEDICARE ACCOUNTS PAYABLE

The CFO Act requires an agency's chief financial officer to develop and maintain an integrated accounting and financial management system which complies with applicable accounting principles and provides for complete and reliable information. Sufficient documentation of this system should be made available to the auditors. The HCFA's Office of the Actuary (OACT), which is responsible for developing the Medicare accounts payable balance using actuarial methods, did not provide us with sufficient documentation of their process and other information necessary to test the accounts payable balance.

Because the accounts payable estimate is a by-product of HCFA's total Medicare actuarial cost estimates, HCFA officials acknowledged that there are inherent uncertainties and very large accumulated amounts involved that make the payables estimates extremely volatile. The HCFA disclosed the volatility of this estimate in their footnotes to the financial statements. In essence, the HCFA officials stated that the accounts payable estimate represents their best estimate under the time constraints required by the financial statements reporting requirement. However, due to time constraints and other priorities, HCFA officials did not provide us with sufficient documentation necessary to test the accounts payable balance.

We attempted to perform other auditing procedures to substantiate the Medicare accounts payable balance by identifying claims where services were provided during FY 1994 but subsequently paid in FY 1995. The HCFA has enhanced its financial reporting capabilities in this area by using its NCHF to identify claims where services were provided during a year but paid in a subsequent year. However, due to processing limitations associated with the NCHF, complete data to test the FY 1994 Medicare accounts payable balances was not available in a timely manner. Therefore, we used the most current NCHF data available for an entire year to test the reasonableness of OACT's FY 1993 actuarial estimated Medicare accounts payable balance. We found discrepancies of about $1.3 billion between the $14.2 billion FY 1993 accounts payable estimate and the related NCHF data for claims where services were provided during FY 1993 but paid during FY 1994. Using the 6 months of data available pertaining to FY 1994, we estimated there could be discrepancies of about $11.5 billion between the payable amount of $24.9 billion reported at September 30, 1994 and the related NCHF data. Although HCFA officials could not explain the cause for the discrepancies, they are attempting to reconcile the differences.

In addition, we analyzed trends of cash disbursements and accounts payable data from FYs 1992 through 1994 to assess the reasonableness of OACT's accounts payable estimate. Our analysis showed a steady and consistent increase in Medicare disbursements of 11 percent from FYs 1992 to 1993 and about 15 percent from FYs 1993 to 1994. However, the accounts payable estimate, which would seem to change in proportion with total Medicare disbursements, showed erratic and inconsistent changes from FYs 1992 to 1994. The accounts payable estimate decreased by 11 percent from FYs 1992 to 1993, but increased 77 percent from FYs 1993 to 1994. The HCFA officials could not explain the cause of this discrepancy.

We are concerned that the actuarial accounts payable estimate may not be accurate for financial statement reporting. We believe that one possible alternative would be to use the NCHF data to estimate the accounts payable. Although there are some obstacles to overcome such as timeliness of the data, our analysis of NCHF monthly reports found that approximately 80 percent of claims where services were provided during FY 1993 but subsequently paid in FY 1994 (i.e., incurred payments) were paid within the first 4 months of FY 1994. We expanded our analysis to include FY 1992 and also found that over 80 percent of the FY 1992 incurred payments were paid within the first 4 months of FY 1993. However, we were unable to determine the actual amount of the discrepancy, therefore, additional analysis of the reasonableness of both estimating techniques needs to be performed. We welcome the opportunity to work with HCFA to resolve these issues.

As a result of the above uncertainties and HCFA not providing sufficient information to us, we were unable to determine the reasonableness of the Medicare accounts payable balance.

WAGE CERTIFICATIONS

The Social Security Administration (SSA) continues to use Internal Revenue Service (IRS) data as the basis for determining the amount of employment tax revenues to transfer to the HI trust fund. This practice was disclosed in Footnote 8 to the financial statements. As previously reported in our FY 1994 CFO report regarding the identical issue with respect to SSA's financial statements,[8] we believe this certification practice does not comply with the Social Security Act. Sections 1817(a) of the Social Security Act has required that wages be "certified" by the Secretary of Health and Human Services on the basis of records "established and maintained" by the Secretary.[9] Because the Act did not anticipate separate wage reportings to IRS and SSA, no provision exists to specifically address the impact of discrepancies between the two systems of wage reporting on the transfers to the trust fund.

[8] *Inspector General's Report on the Social Security Administration's Financial Statements (A-17-94-00520), dated January 1995.*

[9] *Effective March 31, 1995, this was revised to read "Commissioner of Social Security" in place of "Secretary of Health and Human Services."*

The use of the IRS records as the basis of wage reporting to the trust fund has resulted in the HI trust fund receiving approximately $2.6 billion in excess employment taxes for Tax Years (TY) 1978 through 1991. Additional taxes, estimated by SSA to be $1.0 billion, may also have been transferred for TYs 1992 through 1994, but SSA's reconciliations of IRS and SSA wage records for these years have not been completed. In FY 1993 SSA developed a legislative proposal, which, if enacted, would permit SSA to retroactively use reconciled IRS and W-2 data to certify wages and retain employment taxes transferred on this basis. The legislative proposal was agreed upon by Department of Health and Human Services (HHS) and the Department of the Treasury. The SSA did not submit this legislative proposal in FY 1994, but may submit it as part of its next budget and legislative package.

The HCFA bas recognized an estimated $3.6 billion liability in its FY 1994 combined statement of financial position pending resolution of the wage certification issue. The liability offsets the assets that have accrued to the HI trust fund as a result of relying on IRS wage records to transfer amounts to the HI trust fund. The declaration of a liability, however, does not resolve the matter of relying on IRS wage reporting as the basis for certification and trust fund transfer. We continue to believe this certification practice does not comply with the Social Security Act.

FINANCIAL REPORT OVERVIEW

On February 5, 1992, OMB issued a memorandum to CFOs, titled *Financial Statements and Performance Measures*, that suggested (i) the organization and presentation of an overview, (ii) procedures to identify appropriate performance measures, and (iii) procedures to obtain accurate data for program and financial performance measures.

During FY 1993, HCFA was in the process of developing a strategic plan and stated in its FY 1993 financial report overview that the strategic plan would include specific performance indicators and that it would present these indicators in future financial reports. The HCFA strategic plan was publisbed during February 1994 and defined HCFA's mission, goals, and objectives. However, specific performance indicators, whicb measure the progress towards achieving objectives, have not been finalized and were not included in the FY 1994 overview. Without specific program performance indicators, the overview does not provide the information necessary to determine whether HCFA's programs are achieving their mission and intended results. Without this type of information, HCFA's overview did not appear to meet OMB's intent to provide readers with a clear and concise understanding of HCFA's activities, accomplishments, and needs.

OTHER FINANCIAL MATTERS

In addition to the issues discussed above, we identified the following conditions that represent significant issues to HCFA and the reporting of Medicaid financial information. We believe that these issues are not unique to HCFA, but impact the reporting of many Federal grant programs.

MEDICAID ACCOUNTS RECEIVABLE

At HCFA, the Medicaid program was reported on a modified casb accounting basis whicb did not require the recording of the Federal share of Medicaid accounts receivable owed to State agencies by providers, drug manufacturers, insurance agencies, beneficiaries' estates, and other sources. Collections of Medicaid receivables were reported as refunds or offsets by the States on their Medicaid quarterly expenditure reports. The Federal portion of Medicaid accounts receivable are recorded by States in their records and/or financial statements, but the States are not required to report these amounts to HCFA.

To strengthen the CFO Act requirements, OMB issued the Statement of Federal Financial Accounting Standards Number 1, *Accounting for Selected Assets and Liabilities*. This standard states that "a receivable sbould be recognized when a Federal entity establishes a claim to cash or other assets against other entities...If the exact amount is unknown, a reasonable estimate should be made."

We reviewed the most current available financial information, which was 1993, gathered from seven States to determine wbat Medicaid information was available. We found that most of the States reviewed recorded Medicaid receivable data in their records. We also found that many of the States included the Medicaid receivable data in their financial statement receivable balance, although not specifically identified as Medicaid. In addition, the Federal portion of Medicaid receivables due the Federal Government was included by two States in their financial statement balances, although not specifically identified as Medicaid. From this limited review, we believe that the Federal portion of Medicaid accounts receivable being reported by States could be about a billion dollars. However, it was impractical for us to extend our tests to satisfy ourselves as to the fair presentation of the total Medicaid accounts receivable balance.

In a discussion of this matter between representatives from Federal Accounting Standards Advisory Board (FASAB), HCFA, OMB, the General Accounting Office (GAO), the HHS's Assistant Secretary of Management and Budget (ASMB), and Office of Inspector General (OIG), the group concluded that HCFA should disclose this issue in its financial statement. The footnotes to HCFA's financial statements disclosed this issue.

We believe that the Federal portion of Medicaid accounts receivable recorded on States' records and/or financial statements should be included in HCFA's combined statement of financial position if it can be reasonably estimated. We also believe that HCFA has the ability to influence States' reporting of Medicaid receivables. For example, HCFA recently established a new requirement that States maintain a formal system of records for drug rebate receivable and collection data, and disclose such information on the quarterly Medicaid expenditure report. As a result of this new requirement, one State in our review plans to report a drug rebate receivable amount on its FY 1994 financial statements.

MEDICAID ACCOUNTS PAYABLE

At HCFA, the Medicaid program was reported on a modified cash basis which did not require the recording of an accounts payable for the Federal portion of accrued expenses for Medicaid services rendered wbich have not been paid by the States. This included (i) claims for services that have been provided but not yet reported to Medicaid State agencies and (ii) claims for services that have been submitted to Medicaid State agencies but are in process. The Federal portion of the Medicaid accounts payable balances are recorded in States' records and/or financial statements, but the States are not required to report these amounts to HCFA.

To strengthen the CFO Act requirements, OMB issued the Statement of Federal Financial Accounting Standards Number 1, *Accounting for Selected Assets and Liabilities*. This standard states that an example of liabilities to be recognized included accrued entitlement benefits payable applicable to the accrued period but not yet paid. Additionally, FASAB issued an exposure draft *Accounting for Liabilities of the Federal Government*, dated November 7, 1994. This draft suggests that Medicaid program expenses should be recognized when payments are due and payable to recipients, and that a liability should be recognized in the period it occurs if the future outflow of resources is probable and the liability is reasonably estimable.

We reviewed the most current financial information available, which was 1993, gathered from eight States to determine what Medicaid financial information was available. This information disclosed that all eight States accrued in their financial records and/or financial statements (i) an accounts payable amount that included claims for services that had been provided hut were not reported to the Medicaid State agency and claims in process that had not been paid and (ii) an asset amount for the estimated Federal portion the States expected to receive from HCFA for their Medicaid accounts payable. We found that one State specifically identified the Medicaid amount in its financial statement accounts payable balance, however, most did not. Although our limited review indicated that the Medicaid accounts payable balance recorded by States could be billions of dollars, it was impractical for us to extend our tests to satisfy ourselves as to the fair presentation of the total Medicaid accounts payable balance.

We believe that the Federal portion of Medicaid accounts payable recorded in States' records and/or financial statements should be included in HCFA's combined statement of financial position if it can be reasonably estimated. In a discussion of this matter between representatives from FASAB, HCFA, OMB, GAO, ASMB, and OIG, the group concluded that HCFA should disclose this issue in its financial statement. The footnotes to HCFA's financial statements disclosed this issue, however, the final resolution of how to report the States' estimate for Medicaid accounts payable is still under consideration by FASAB. The FASAB's final standard on accounting for liabilities of the Federal Government should be issued in the near future. However, an April 1995 news release from FASAB indicates that Federal entities should report the full liability due to the third party entities (i.e., State governments) and the Federal entities should recognize an accrual for amounts due as of the Federal reporting date.

RECOMMENDATIONS

We recommend that HCFA:

1. Examine the actuarial accounts payable estimate and determine whether an alternative estimating method based on NCHF or Medicare contractors' data would provide a less volatile and more measurable basis for financial statement reporting.

2. Obtain from FASAB the results of their analysis of accounting for liabilities of the Federal Government and a standard of accounting for Medicaid accounts receivable, and apply its recommendation to the Medicaid program. If appropriate, determine the amount of Medicaid accounts payable and receivables recorded in the records at the State agencies and include the Federal share in HCFA's combined statement of financial position.

3. Develop performance indicators for the Overview in accordance with prescribed guidance.

We discussed a draft of this report with HCFA officials who generally concurred with its findings and recommendations. We have incorporated the officials' comments where appropriate.

MANAGEMENT'S RESPONSIBILITIES

The HCFA's management is responsible for:

- Designing and maintaining an internal control structure that provides reasonable, but not absolute, assurance that the following objectives are met:

  transactions, including those related to obligations and costs, are executed in compliance with applicable laws and regulations;

- funds, property, and other assets are safeguarded against waste, loss, and unauthorized use or misappropriation;
- transactions are properly recorded and accounted for to prepare reliable financial statements; and
- data that support related performance measures are properly recorded and accounted for to permit preparation of reliable and complete performance information.

AUDITOR RESPONSIBILITIES AND METHODOLOGIES

Our responsibilities are:

- To plan our work to include the combined statement of financial position.
- To obtain an understanding of the internal control structure policies and procedures and assess the control risks applicable to HCFA's reported performance measurement data.
- To report the results of our review of HCFA's internal control structure to the extent that its inadequate design or ineffective operation, if applicable, could materially affect HCFA's combined statement of financial position.
- To report the results of our tests of HCFA's compliance with applicable laws and regulations that could materially affect the combined statement of financial position.

Our tests of applicable internal controls and compliance were performed to determine the extent of our procedures necessary for expressing an opinion on the combined statement of financial position and to report findings resulting from our control and compliance testing. We do not express separate opinions about the adequacy of the internal control structure or compliance with laws and regulations.

Because of inherent limitations in any internal control structure, losses, noncompliance, or misstatement may nevertheless occur and not be detected. Also, projection of any evaluation of the internal control structure to future periods is subject to the risk that controls may become inadequate because of changes in conditions or that the degree of compliance with controls may deteriorate. Our consideration of the internal control structure would not necessarily disclose all matters in the internal control structure that might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses.

To fulfill these responsibilities we:

- Obtained an understanding of HCFA's internal control structure policies and procedures and assessed the control risks.
- Evaluated and tested the operation or the relevant internal control structure policies and procedures designed by management to provide reasonable, but not absolute, assurance that the above management objectives were met for the following significant cycles, classes of transactions, and account balances:
  - Medicare Accounts Receivable
  - Medicaid Accounts Receivable
  - Medicaid Accounts Payable
  - Overall Compliance with Laws and Regulations
  - Advances and Prepayments
  - Financial Reporting
  - Treasury

- Tested compliance with selected provisions of the following laws and regulations that may materially affect the statement of financial position or are specified in OMB Bulletin 93-06:

  - Social Security Act, as amended
  - Antideficiency Act
  - Budget Accounting and Procedures Act of 1950
  - CFO Act of 1990
  - FMFIA of 1982
  - Prompt Payment Act

- Compared the HHS' most recent FMFIA report on internal controls, that included HCFA, dated December 1994 with the results of our tests of internal controls.

June G Brown

June Gibbs Brown
Inspector General
Department of Health and Human Services

Glossary

Actuarial Soundness: A measure of the adequacy of Hospital Insurance and Supplementary Medical Insurance financing as determined by the difference between trust fund assets and liabilities for specified periods.

Administrative Costs: General term that refers to Medicare administrative costs, Medicaid administrative costs, and HCFA administrative costs. Medicare administrative costs are comprised of the Medicare related outlays of the Program Management account, the PRO outlays, and non-HCFA administrative outlays. Medicaid administrative costs refer to the Federal share of the States' expenditures for administration of the Medicaid program. HCFA administrative costs are the costs of operating HCFA, e.g. salaries and expenses, facilities, equipment, rent and utilities, etc. These costs are reflected in the Program Management account.

Beneficiary: A person entitled under the law to receive Medicare or Medicaid benefits (also referred to as an "enrollee").

Benefit Payments: Funds outlayed and accrued expenses for services delivered to beneficiaries.

Carrier: A private business, usually an insurance company, which contracts with HCFA to receive, review, and pay physician and supplier claims.

Cost-Based Health Maintenance Organization (HMO/ Competitive Medical Plan or "CMP"): A type of managed care organization that will pay for all of the enrollees/members' medical care costs in return for a monthly premium, plus any applicable deductible or co-payment. The HMO will pay for all hospital costs (generally referred to as Part A) and physician costs (generally referred to as Part B) that it has arranged for and ordered. Like a health care prepayment plan (HCPP), except for out of area emergency services, if a Medicare member/enrollee chooses to obtain services that have not been arranged for by the HMO, he/she is liable for any applicable deductible and co-insurance amounts, with the balance paid by the regional Medicare intermediary and/or carrier.

Demonstrations: Projects and contracts that HCFA has signed with various health care organizations. These contracts allow HCFA to test various specific attributes such as payment methodologies, preventive care, social care, etc., and to determine if such projects/pilots should be continued or expanded to meet the health care needs of the nation. Demonstrations are used to evaluate the effects and impacts of various health care initiatives and the cost implications to the public.

Discretionary Spending: Outlays of funds subject to the Federal appropriations process.

DSH (Disproportionate Share Hospital): A hospital with a disproportionately large share of low-income patients. Under Medicaid, States augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.

DME (Durable Medical Equipment): Purchased or rented items such as hospital beds, wheelchairs, or oxygen equipment used in a patient's home.

Expenditure: Expenditure refers to budgeted funds actually spent. When used in the discussion of the Medicaid program, expenditures refer to funds actually spent as reported by the States.

Expense: An outlay or an accrued liability for services incurred in the current period.

Federal General Revenues: Federal tax revenues (principally individual and business income taxes) not earmarked for a particular use.

FICA (Federal Insurance Contribution Act) Payroll Tax: Medicare's share of FICA is used to fund the HI Trust Fund. In FY 1994, employers and employees each contributed 1.45 percent of taxable annual wages, with no limitations, to the HI Trust Fund.

Financial Statements: Combined Statement of Financial Position (assets, liabilities, and net position) and Operations and Changes in Net Position (revenues and expenses).

FMAP (Federal Medical Assistance Percentage): The portion of the Medicaid program which is paid by the Federal government.

FMFIA (Federal Managers' Financial Integrity Act): A program to identify management inefficiencies and areas vulnerable to fraud and abuse and to correct such weaknesses with improved internal controls.

Health Care Prepayment Plan (HCPP): A type of managed care organization. In return for a monthly premium, plus any applicable deductible or co-payment, all or most of an individual's physician services will be provided by the HCPP. The HCPP will pay for all services it has arranged for (and any emergency services), whether provided by its own physicians or its contracted network of physicians . If a member enrolled in an HCPP chooses to receive services that have not been arranged for by the HCPP, he/she is liable for any applicable Medicare deductible and/or coinsurance amounts, and any balance would be paid by the regional Medicare carrier.

High Risk Area: A potential flaw in management controls requiring management attention and possible corrective action.

ICF/MR: Intermediate care facility for the mentally retarded.

Hospital Insurance (HI) : See "Part A."

Intermediary: A private business, usually an insurance company, which contracts with HCFA to receive, review, and pay hospital and other institutional provider benefit claims.

Internal Controls: Management systems and policies for reasonably documenting, monitoring, and correcting operational processes to prevent and detect waste and to ensure proper payment.

Mandatory Spending: Outlays for entitlement programs (Medicare and Medicaid) that are not subject to the Federal appropriations process.

Material Weakness: A serious flaw in management controls requiring high-priority corrective action.

Medicare Contractor: A collective term for carriers and intermediaries.

Medicare Trust Funds: Treasury accounts established by the Social Security Act for the receipt of revenues, maintenance of reserves, and disbursement of payments for the HI and SMI programs.

MR/UR (Medical Review/Utilization Review): Contractor reviews of Medicare claims to ensure that the service was necessary and appropriate.

MSP (Medicare Secondary Payer): A statutory requirement that private insurers providing general health insurance coverage to Medicare beneficiaries pay beneficiary claims as primary payers.

Obligation: Budgeted funds committed to be spent.

Outlay: Budgeted funds actually spent. When used in the discussion of the Medicaid program, outlays refer to amounts advanced to the States for Medicaid benefits.

Part A: Medicare Hospital Insurance, also referred to as "HI."

Part B: Medicare Supplementary Medical Insurance, also referred to as "SMI."

Payment Safeguards: Activities to prevent and recover inappropriate Medicare benefit payments, including MSP, MR/UR, provider audits, and fraud and abuse detection.

PRO (Peer Review Organization): PROs monitor the quality of care provided to Medicare beneficiaries to ensure that health care services are medically necessary, appropriate, provided in a proper setting, and are of acceptable quality.

Productivity Investments: Spending aimed at increasing contractor operational efficiency and productivity through improved work methods, application of technology, etc..

Program Management: HCFA's operational account. Program Management supplies the agency with the resources to administer Medicare, the Federal portion of Medicaid, and other agency responsibilities. The components of Program Management are: Medicare contractors, survey and certification, research, and administrative costs.

Provider: A health care professional or organization providing medical services.

Recipient: An individual covered by the Medicaid program, however, now referred to as a beneficiary.

Risk-Based Health Maintenance Organization (HMO)/ Competitive Medical Plan (CMP): A type of managed care organization. After any applicable deductible or co-payment, <u>all</u> of an enrollee/member's medical care costs are paid for in return for a monthly premium. However, due to the "lock-in" provision, all of the enrollee/member's services (except for out of area emergency services) must be arranged for by the risk HMO. Should the Medicare enrollee/member choose to obtain service not arranged for by the plan , he/she will be liable for the costs. Neither the HMO nor the Medicare program will pay for services from providers that are not part of the HMO's health care system/network.

Revenue: The recognition of income earned and the use of appropriated capital from the rendering of services in the current period.

SECA (Self Employment Contribution Act) Payroll Tax: Medicare's share of SECA is used to fund the HI Trust Fund. In FY 1994, self-employed individuals contributed 2.9 percent of taxable annual income, with no limitation.

State Certification: Inspections of Medicare provider facilities to ensure compliance with Federal health, safety, and program standards.

Supplementary Medical Insurance (SMI): See "Part B."

Tax and Donations: State programs under which funds collected by the State through certain health care related taxes and provider-related donations were used to effectively increase the amount of Federal Medicaid reimbursement without a comparable increase in State Medicaid funding or provider reimbursement levels.

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U.S. Department of Health and Human Services

Donna E. Shalala, Secretary

Health Care Financing Administration

Bruce C. Vladeck, Administrator

William L. Broglie, Chief Financial Officer

Lee Mosedale, Director, Office of Financial Management

John Trout, CFO Report Coordinator

HCFA staff contributing to this report include: Lynn Orlosky, CFO Report Analyst; members of the Division of Accounting (Gerald M. Hankin, Director; Donna E. Kettish, Accountant; Robert Fox, Accountant; and Eric Holmberg, Accountant); members of the HCFA Division of Budget; and staff in other HCFA components.

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